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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

B CUT 2
(cont'd)

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence
for

October 11, 1983

VOLUME 47

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Blah
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Shawsoft
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1 ROYAL COMMISSION OF INQUIRY INTO CERTAIN
2 DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

3

4 Hearing held on the 8th Floor,
5 180 Dundas Street West, Toronto,
Ontario, on Tuesday, the 11th
6 day of October, 1983.

7 - - - - -

8 THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
9 THOMAS MILLAR - Administrator
10 MURRAY R. ELLIOT - Registrar

11 - - - - -

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25



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TORONTO, ONTARIO

(b)

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A/ET/ak ---Upon commencing at 10:00 a.m.

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THE COMMISSIONER: Yes, Mr. Scott?

4

DR. ERNEST CUTZ, Recalled

5

MR. SCOTT: Good morning,

6

Mr. Commissioner.

7

EXAMINATION BY MR. SCOTT:

8

Q. Good morning, Dr. Cutz. You have been shuffled around a bit but now we are going to come right at you and get you out of here today.

9

You told me when I was examining you that when you do an autopsy at the Hospital that is not a coroner's autopsy that you do it as a consultant clinician; is that correct?

10

A. That is correct, yes.

11

Q. And I take it that your report, therefore, is in the nature of a study of the disease to assist the clinician in determining whether the cause of death he - or the diagnosis that he has made is supported or not?

12

A. Yes, that would be part of it, but I think the significant part of the autopsy is really to study the disease process.

13

Q. And do I --

14

A. And among other things is also to determine the cause of death.

15

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Q. Yes. And do I take it, therefore, that when you are performing an autopsy in that sense your function is really to assist the clinician who is in charge of diagnosing the disease?

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A. Yes. He looked after the patient during life and then he arrived at certain diagnoses, and our purpose is really to study the patient by other methods.

Q. Yes.

A. To see whether such a diagnosis was correct and what new we can learn from the case under consideration.

Q. Now we have heard that Dr. Freedom has a cross appointment to pathology.

A. That is correct.

Q. And that he attends or at least inspects the results of the gross autopsy on the heart?

A. Yes. Dr. Freedom has a special position there in that he has a wide knowledge and interest in the abnormalities of congenital heart disease, and he is very well placed to, for instance, to correlation between studies done in people, particularly catheterization, and then the actual abnormality of the heart as we can see it.



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Q. You see you are getting way ahead of me because the answer to that question I think would have been yes, and then I was going to ask you another one, but you told me the answer already, so if you can just tend to the question.

I take it that the purpose of Dr. Freedom's examination is not to perform the work of a pathologist?

A. No, it is not.

Q. But that his purpose is to

examine the heart to determine the extent to which, for example, the catheterization process has accurately predicted what the heart and its components look like?

A. That is correct, yes.

Q. And he has a further purpose

which is to determine the extent to which the cardiologist's assessment of the impact of the surgery, whether it corrected it or failed to correct the disorder, is demonstrated to be the case by the actual autopsy?

A. That is correct, yes.

Q. But the pathological work is yours; not his?

A. Yes, that is correct.



1

2

Q. All right. Now when you do an autopsy for the coroner on the other hand you are provided with a coroner's warrant?

5

A. That is correct, yes.

6

Q. And I take it then in some cases, although perhaps not all, it is for the coroner to say to what the pathologist should normally direct his attention?

7

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A. Yes. It depends on the kind of cases. If we are dealing with an in-hospital death, that is a patient who has been treated at the hospital and has a known disease or diagnosis, there may be some circumstances under which this would become a corner's case.

Now the coroner should let us know what the unusual circumstance is and/or what in particular we should be looking for from a medical, legal or other point of view.

Q. I see. And I take it that you would just then make your report in light of his requests and outline any other significant information that you find?

A. That is correct, yes.

Q. Now in a coroner's case are you expected to make some determination as to the



1

2

cause of death?

3

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A. Yes. That would be the primary purpose.

5

6

7

Q. I take it that when you are acting under a coroner's warrant you also perform any other functions or conduct any other examinations that the coroner may require?

8

9

10

11

A. That is correct, yes.

12

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Q. But he is in charge?

18

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A. Yes, he is in charge of the case.

Q. Yes. Well, I want to talk just for a moment about pathological examination and what you can learn from it, and I take it that there are really three kinds of findings that can be made.

A. Well, there are three kinds of findings in terms if one is talking about causes of death.

Q. All right. Can you tell the Commission how you characterize those three kinds of findings? Give them a name, first of all.

A. Yes. I would categorize it from the point of view of a pathologist into three broad categories; one which would be an anatomical cause of death, and this would mean --



1

2

Q. We will come back to it in a
moment.

3

A. Yes.

4

Q. Just give me the name of it:
anatomical cause of death, yes.

5

A. And biochemical.

6

Q. Yes.

7

A. And what I would call a
pathophysiological.

8

Q. All right. Now I want to deal
with each of these one by one, and I want you to
assist me by telling the Commissioner to what extent
if any a pathologist at autopsy can learn anything
about one of those three causes of death? Are you
with me so far?

9

A. Yes.

10

Q. Now first of all the anatomical
cause of death: I take it that is pretty clear?

11

A. Yes. Anatomical would imply
a kind of lesion or abnormality that we can see
with either a naked eye or microscopically which
either by previous experience or knowledge would be
considered as being significant to cause death.

12

Q. All right. So the first,
anatomical, I take it at autopsy with or without the

13

14



1
2 assistance of a microscope, you can determine the
3 extent to which there may be by visual inspection
4 an anatomical cause?

5 A. That is correct, yes.

6 Q. Now what about biochemical
7 cause?

8 A. A biochemical cause would
9 usually be a type of finding which may not necessarily
10 be obvious to a naked eye, but would be determined
11 by measurements of substances either endogenous to
12 the body or drugs in the blood or tissues, and then
13 by determining the levels and/or sort of interpreting
14 it in the context of the case, and even in the absence
15 of, say, anatomical findings then this biochemical
16 abnormality may be considered as being the cause of
17 death.

18 Q. All right. And in the case of
19 a potential biochemical cause can you tell me what
20 the function of a pathologist is and what is not the
21 function of a pathologist?

22 A. A pathologist would take
23 samples and provide them to the biochemistry or
24 toxicology laboratory for analysis.

25 Q. Yes. And he then gets a
reading back?



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A. Yes. He will get the results back.

4

5

6

Q. Yes. And the results, of course we have heard are no part of the pathologist's doing?

7

8

A. No. The results would not be generated by the pathologist.

9

10

Q. All right. Now when you get a result what role if any does the pathologist play in using that result?

11

12

13

A. Well, the pathologist has to interpret these findings or results in light of the whole case.

14

Q. Yes.

15

A. As to how it fits or doesn't fit the whole picture.

16

17

18

Q. And in order to do that are you dependent in a major way on expertise that may be provided by a pharmacologist?

19

A. Yes, I would said so.

20

21

22

Q. Yes. And you either get that expertise by reading a book or by consulting a pharmacologist?

A. That is correct.

23

24

25

Q. So would I have it right that



1

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when we are dealing with the biochemical cause
when the reading comes back the assessment you make
of it in terms of the whole case is really dependent
on what you understand the pharmacologist to say
about that kind of a reading?

7

A. Yes, that is correct.

8

Q. All right. Now just to go
back to the anatomical cause for a moment, you have
told us that that means an examination conducted
exclusively by the pathologist in which he sees by
the naked eye or under microscope a potential cause?

12

A. That is correct, yes.

13

Q. And that would include tumours
and hemorrhages and plumbing defects such as holes
in the septum?

15

A.. Yes.

16

Q. And diseases of the myocardium?

17

A. That is correct, yes.

18

Q. Ischaemia?

19

A. Yes.

20

Q. All right now. Let's come to
pathophysiological, and what do you mean by that
area of examination?

22

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A. Well, pathophysiological would
mean disturbed function, and this is something which



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would be observed during life and could usually be
measured or determined by various instruments.

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This again there may be sometimes a correlation between this functional abnormality and say anatomical finding, but often times there is no correlate or there is no lesion we can pinpoint as being the anatomical cause.

9

Q. All right. On the patho-
physiological are you dependent in part on readings made in life such as electric readings of the brain or electric readings of the heart?

10

A. Yes, that is correct.

11

Q. And those readings of course have been taken by someone other than you?

12

A. That is correct, yes.

13

Q. And are simply in your file at autopsy?

14

A. Yes.

15

Q. Or it may be?

16

A. Yes. They would be part of the patient's chart.

17

Q. Yes. And I take it that the one essentially responsible for the analysis of those readings is again the clinician?

18

A. Yes.

19

20

21

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Q. And your function is simply to
see whether there is any correlation between that
reading and any anatomical disorder you discover?

5

A. That is correct, yes.

6

Q. And, for example, if I was
being tested right now for a heart ailment by my
clinician and I suffered a fibrillation that might
show on the electrical reading?

9

A. That is correct, yes.

10

Q. Ante mortem?

11

A. Yes.

12

Q. And if I regrettably died, a
view not everywhere regarded with regret, and you
had the opportunity to perform the autopsy I take
it you would be given in the file my ECG?

15

A. Yes.

16

Q. And you would consult with
my clinician if you needed to to judge about what
sense he made of the reading?

19

A. Yes.

20

Q. And I take it at autopsy
because I had a fibrillation there would be nothing
that revealed why I had died?

22

A. That is correct, yes.

23

Q. So that in these three cases

24

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I take it the pathologist is really only in control
and is exclusively able to act in the case of an
anatomical defect?

5

A. That is correct.

6

7

8

9

Q. In a biochemical cause or in
a pathophysiological cause he is dependent to a very
large degree on the knowledge of the pharmacologist
in the first case and the knowledge of the clinician
in the second case?

10

A. Yes, that is correct.

11

12

13

14

Q. Now I want to take you to a
list that Dr. Rowe prepared for the Commission of
some 14 causes of death, and I have asked you to
read his evidence in this connection, have I not?

15

A. Yes, you did.

16

Q. And you have done so?

17

A. Yes, I did.

18

Q. Now perhaps we can move through
them fairly quickly. And what I want to ask you about
each of these cases is assuming that the cause of
death was the enumerated cause listed by Dr. Rowe,
would you expect at autopsy to see any evidence that
supported that cause?

22

Do you understand the question?

23

A. Yes, I do.

24

25



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Q. All right. Now let's take,
first of all, his first case which was what he
called pump failure.

3

4

A. Yes.

5

6

Q. And I think he said that the
pump failure might arise out of an anatomical defect
in the heart which over the passage of time simply
led the heart to fail?

7

8

A. Yes.

9

10

11

12

Q. Now dealing with that I take
it if there was an anatomical defect you would expect
to see it at autopsy?

13

14

A. Yes, that is correct.

15

16

Q. But would you expect to see

17

any evidence that the pump had failed?

18

19

A. Yes, we would see in such a
case, we would see signs of heart failure in other
organs. For example, congestion of the various
organs such as liver, lung, kidneys, et cetera, yes.

20

21

Q. Are there cases where you would
not expect to see evidence of pump failure at
autopsy?

22

23

A. Yes, in instantaneous type of
death you would not see evidence of pump failure.

24

25

Q. So if you had a sudden death



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which was attributed to a pump failure where there
was an anatomical defect, do I understand that you
might not therefore see at autopsy any evidence
pointing to that cause?

3

A. That is correct.

4

Q. But nonetheless you could not
exclude the cause?

5

A. No, yes.

6

Q. Now his/category was hypoxia.

7

A. Yes.

8

Q. Would you expect in the case
of hypoxia to see any evidence pointing toward it at
autopsy?

9

A. Yes. You would see changes
related to hypoxia, but here it depends on the time
interval of survival between when the hypoxia took
place and when the patient died.

10

Q. Yes.

11

A. So there is a minimum time
required before you would start to see these changes.

12

Q. And is that minimum time about
24 hours?

13

A. Something in that neighbourhood,
yes.

14

Q. All right. So if the hypoxic

15

16



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3 incident had occurred 24 hours before death I take
4 it that there would be no anatomical changes or
5 there might not be anatomical changes which would
point to that cause?

6

7

A. I think 24 hours you would
expect to see some changes.

8

9

Q. All right.

10

11

12

13

14

A. But less than 24 hours you
might not.

Q. All right. So that in a case
where the death occurs less than 24 hours after the
hypoxic spell you would not necessarily expect to
see and probably would not see any evidence at
autopsy pointing to that cause?

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Q. But nonetheless, if the clinician had observed the spell you could not discount it as a cause of death?

5

A. That is right.

6

Q. Now, his third category was sepsis; would you have expected to see any evidence of sepsis in the case of a child's death when you are performing the autopsy?

9

A. Yes, you would.

10

11

Q. Is there a time frame there as well?

12

13

14

15

16

A. There would be a time frame in terms of tissue reaction. That is in the event of infection you would get reaction of the tissues to the infected agent by presence of inflammatory type cells, and again you require certain time interval before you start to see this.

17

Q. What time interval?

18

A. I would think it is somewhere around nine hours.

19

20

21

22

23

24

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Q. All right. Do I understand from that, Dr. Cutz, that if the septic - I am not sure if that is the adverb, that is a plumbing term; if the sepsis occurred that led to death, occurred within nine hours of death, I take it that there



B.2

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2 would not probably be any evidence at autopsy from
3 which you could conclude that that was the cause of
4 death?

5 A. Yes. You might not see changes
6 in the tissues but in order to say that the sepsis
7 took place you would have to demonstrate an organism
by culture.

8 Q. What I am asking you is, if the
9 clinician has concluded that sepsis was the cause of
10 death, is there any - will you always at autopsy be
11 able to see evidence of that sepsis?

12 A. If it was overwhelming and of
13 short duration you would not see changes.

14 Q. All right. Well now, the fourth
15 category was respiratory illness, and would you see
16 evidence of that at autopsy if the clinician had
assigned that as the cause of death?

17 A. You usually would.

18 Q. Are there cases where you would
19 not?

20 A. Again I think it would depend
on the time interval between the insult and the death
21 from that particular cause.

22 Q. Can you give us any information
23 as to what that time interval might be?

24

25



B.3

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A. Again, if the respiratory

illness is due to infection then about the same rule
would apply.

5

Q. How many hours is that?

6

A. I would think about nine hours

7

before you start to see a significant inflammatory
reaction. If it is due to some other agents, physical
agents, such as toxic fumes or things like that, you
may see a reaction to that.

10

11

Q. Well, what you see at autopsy

is the inflammation of the organs?

12

13

A. Usually that would be one of

the manifestations.

14

15

16

Q. Do I have it right that if the
onset of the respiratory illness is within nine hours
preceding death you may not at autopsy see
inflammation of the organs?

17

A. That is correct, yes.

18

19

Q. And therefore you may not be
able at autopsy to find anything to sustain the
clinician's assessment of the cause?

20

A. Yes, that is correct.

21

22

23

THE COMMISSIONER: I take it, Doctor,
that notwithstanding the short interval, there could
be death? Do you follow me? I mean if it takes nine

24

25



B.4

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2 hours for this disease to kill a man off then it will
3 show up. I take it you can have a respiratory illness
4 that will kill you within nine hours and yet will show
5 nothing, is that what you are telling me?

6 THE WITNESS: Well, in the case of
7 respiratory illness you usually see changes, but it
8 is a question as to whether the changes you produce
9 in your organs are the ones that kill you, or is it
10 the agent itself. It depends on many other factors,
it is not as simple.

11 THE COMMISSIONER: The sort of thing
12 I was worried about though was this; you say it takes
13 nine hours to show up on the organs, or pathologically
14 to show up, but it may also take nine hours to kill.

15 THE WITNESS: Yes. Correct, yes.

16 THE COMMISSIONER: What is your
experience, does it usually show up?

17 THE WITNESS: No. I think this nine-
18 hour interval it refers to the time where you can see
19 the inflammatory cells under the microscope, and this
20 would be an indication, or a definite indication that
there is some infectious process going on.

21 MR. SCOTT: Q. Dr. Cutz - I am sorry,
22 are you finished, Mr. Commissioner?

23 THE COMMISSIONER: No, no. I just --

24

25



B.5

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2 MR. SCOTT: Can I ask one question
3 that may clear it up?

4 THE COMMISSIONER: Yes.

5 MR. SCOTT: Q. I take it that a
6 respiratory illness may kill very quickly and much
7 shorter than nine hours?

8 A. Yes.

9 Q. There is no doubt about that?

10 A. No.

11 Q. And what you are saying is that
12 the respiratory illness leaves evidence of itself only
13 by working - I shouldn't say only, but in one way by
14 working an inflammation of the tissues?

15 A. That is correct, yes.

16 Q. And it takes a period of life
17 of at least nine hours for that inflammation to
18 register on the tissues?

19 A. That is correct.

20 Q. So that if a child dies of a
21 sudden onset of respiratory illness, and dies within
22 nine hours, I take it that you may find no evidence
23 pointing to the clinician's diagnosis?

24 A. Yes, that is correct.

25 Q. That wouldn't surprise you?

A. No, it would not.



B.6

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Q. Now the fifth, of Dr. Rowe's cases was instability of temperature, and would you expect at autopsy to find any evidence of that?

5

6

A. No, you would not find any evidence of that.

7

8

9

Q. Now the sixth was low birth weight, and I take it that while you can assess the weight of a baby at death, apart from the chart, you know nothing about the birth weight of the baby?

10

11

A. Well, you would see and weigh the baby as part of the autopsy.

12

13

14

Q. At death?

A. At death, yes.

15

16

17

18

Q. But that tells you nothing about the birth weight?

A. No.

19

20

21

22

23

24

25

Q. And is birth weight a pathological criteria that you can apply as opposed to a clinician?

A. Well, it is well known that low birth weight infants are at higher risk for many diseases and would be more susceptible to die from causes which in a bigger infant or a full-term infant may not be as significant.

Q. And the clinicians have already



B.7

1

2 come forward and told us about that?

3 A. Yes.

4 Q. What I want to get at is, if
5 that was a cause of death, is it something which you
6 would expect to verify at autopsy?

7 A. No, it would be considered as
8 a factor but it cannot be considered as a primary
9 cause of death.

10 THE COMMISSIONER: I don't see how it
11 could be a cause of death. Perhaps I should have
12 objected to this back when Dr. Rowe was giving it.
13 Low birth weight is, I would have thought as Dr. Cutz
14 said, it may contribute to some other causes.

15 MR. SCOTT: That is not what Dr. Rowe
16 said. Dr. Rowe's evidence was that the low birth
17 weight of a baby could in the manner he described be
18 the cause of death. I will dig it up later. I under-
19 stand what you say, Mr. Commissioner, that you and I
20 might presume that it would simply be a background
21 factor which would make it easier for the cause of
22 death to operate and to operate more quickly.

23 Dr. Rowe's evidence, and I think
24 supported by the cardiologists is, no, that it can be
25 that the birth weight essentially, the birth weight
being low I think he said that it drains, it places



B.8

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2 increasing demands on the operation of the heart.

3

4 however, that low birth weight is not a cause of death?

5

6 it as a cause of death.

7

8 THE COMMISSIONER: Not the primary
9 cause of death.

10

11 THE WITNESS: Yes, it is a contributing
12 factor.

13

14 MR. SCOTT: Q. Did you read Dr. Rowe's
15 evidence on that subject?

16

A. Yes, I did.

17

Q. How did you understand it?

18

19 A. I think this was to imply that
20 low birth weight infants, particularly if premature,
21 a premature infant would have a much lower energy
22 reserve to cope with whatever stress would be put up
23 on him by either the heart disease or other factors.
24 So that in such a situation a low birth weight infant
25 is at higher risk of dying, but I don't think ---

20

21 Q. Well, at page 3371, just so we
22 will have it clear, Dr. Rowe says, and I am cutting
23 into a paragraph, but beginning at line 23:

24

25

"But no doubt that in a large number
of low birth weight babies the brain



B.9

1

2

"function has certain immaturity.

3

"Q. Yes. Those babies lack fat I
take it, characteristically?

5

"A. They do lack fat, yes.

6

"Q. Does that have any impact on the
need for oxygen in the baby's system?

7

"A. Well, they have very little in
the way of energy reserves.

9

"Q. When you say energy reserves,
what do you mean?

11

"A. I mean the fuel by which the body
can function is limited.

12

"Q. All right. Does that have any
impact on the possibility of heart
stoppage?

15

"A. Yes, it does.

16

"Q. Yes. And how does it work, what's
the process?

18

"A. Well, the more fuel reserves you
have the longer it's possible to go if
you are stressed as a baby of that
weight. In taking it in its extreme
form, the baby who has a good reserve
of sugar in the liver and heart will
survive hypoxia for a longer period

24

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B.10

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"than a baby who has limited reserves of those substances. I can't give you all the biochemical associations of that sort, but I think that's fairly definitely accepted.

"Q. Well, what I'm trying to get at is whether in the case ... ",

and you see I even had trouble with those doctors:

" ... is whether in the case of a very low birth weight baby there is a connection between that birth weight and heart stoppage that may exist irrespective of the presence or absence of heart defect?

"A. Yes. We're not quite sure why that is but there has been an observed phenomena that babies of that weight are subject to sudden and unexpected death, even though the heart may be normal."

Now, first of all, Dr. Cutz, that is the evidence of Dr. Rowe and I take it that evidence is within his expertise rather than yours?

A. Of course, yes.

Q. And the question I ask is, if



B.11

1

2 that is a cause of death in a baby, as Dr. Rowe says
3 it may be, would you expect at autopsy to find
4 anything necessarily to vindicate that cause?

5 A. Yes, I think in the premature
6 low birth weight infants there is a number of
7 complications which occur in sort of a regular
8 fashion. I think in the majority of such cases
9 you would find anatomical findings which would
explain that.

10

Q. Like what?

11

A. For instance, there is a high
12 incidence of respiratory disease because of lung
13 immaturity, so they die of respiratory failure. There
14 is a high incidence of hemorrhage particularly in the
15 brain and/or other organs, and so they die from
hemorrhage.

16

Q. Well, Dr. Rowe is talking about
17 the phenomena of low birth weight, no anatomical
18 defect, but the low birth weight causing the heart
19 to stop, and you have conceded that that is within
his expertise?

20

A. Yes, that's right.

21

Q. Now do I understand you to say
22 that when that event occurs, if the clinician judges
23 it to have occurred, you may find evidence of brain
24 hemorrhage?

25



B.12

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A. Yes.

2

Q. And lung hemorrhage of some kind?

3

A. Yes, usually there is a number
4 of findings you would see.

5

6

Q. And are those findings
7 responsive to any time frame?

8

A. Yes, it would again depend on
the time between that it occurred and death.

9

Q. And so what are we talking

10 about, nine hours?

11

12

13

14

A. Well again, this is not a
general rule. The nine hours I think it applies to
the inflammation but the other findings it depends on
what you are talking about, it would be a different
time frame.

15

16

17

18

Q. If the death occurred, as
Dr. Rowe characterizes it, and was sudden and
unexpected, I suggest to you that you might not find
evidence pointing toward it at autopsy?

19

A. That is correct.

20

21

22

Q. Now I don't want to take you
all through these, but Dr. Rowe described four kinds
of conduction failures, and do you remember that in
his evidence?

23

A. Yes, I do.

24

25



B.13

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Q. Which caused death. Would I
have it right that you would not at autopsy expect to
find evidence of those conduction failures without
doing a conduction failure study of the type we have
earlier talked about?

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A. Yes. This would be quite a time consuming and extensive study if you wanted to demonstrate an anatomical abnormality in the conduction system but to a naked eye inspection it is something you cannot really say.

Q. Well, I should tell you that one of my jobs here is to get a report that will encourage a grant to the Hospital that will permit you to do these conduction studies right in place.

But leaving those conduction studies aside, and they have been described by you and others to the Commissioner as being long and elaborate and taking many months I take it?

A. Yes, that is correct.

Q. Leaving those aside, I take it that you would not expect to find evidence pointing to conduction failure death at autopsy?

A. No, not by a routine examination.

Q. All right. Well now, the next cause of death or cause of heart stoppage assigned by Dr. Rowe was acidosis. Would you expect at autopsy to see anything of that to confirm or to offset the clinician's judgment?

24
25



1

2 A. Well, you would see nothing.

3

Q. No. The twelfth cause of

4

the heart stoppage that Dr. Rowe gave was apnea. At
autopsy would you expect to see anything that pointed
to the clinician's assignment of apnea as a cause?

5

A. Sometimes you may see changes

6

but on a routine cursory examination you would not
see any particular lesion which you can say the
patient died from apnea.

7

Q. So that I take it that

8

in the kind of autopsy that is done at Sick
Children's Hospital you would not normally expect
to see anything at autopsy that pointed to apnea
as a cause?

9

A. Well, as I mentioned before,
sometimes by, say, a detailed examination of brain
you can find changes in the respiratory centre or
areas which control respiration. You may find
anatomical changes which you can assign as being
the cause or contributing to the apnea.

10

Q. In what percentage of cases
would you expect to see nothing where apnea was the
cause of heart stoppage?

11

A. Well, I think perhaps Dr.
Becker knows this better but I would think about

12

13

14



1

2 50 per cent you don't see anything.

3 Q. All right. Now, the
4 thirteenth cause of death was anemia, anemia causing
5 heart stoppage. Would you expect to see anything
6 pointing toward that at autopsy?

7 A. Yes, you may see, again,
8 depending upon the duration and the degree of anemia,
9 but this again would be something which would be
10 determined by examining the blood picture of the
11 patient. There may be changes in tissues which would
12 suggest or confirm the presence of anemia.

13 Q. And I take it that there
14 may be cases where there is no evidence pointing to
15 anemia as the cause although the clinician has
16 assigned it?

17 A. That is correct, yes.

18 Q. Yes. Can you divide those,
19 is it 50/50, or what is the ...

20 A. It is not a very common
21 cause.

22 Q. The question I am asking
23 you is, can you characterize how often you are
24 likely to see evidence that supports the clinician's
25 assessment that anemia is the cause?

A. I cannot give a figure on



1

2 that because such cases are quite rare?

3

Q. Yes.

4

A. And I would think that if we don't really see in the tissues which would point to anemia we would probably not seriously consider it.

5

6

Q. In 36 deaths that occurred in the cardiac wards of Sick Children's Hospital between July 1st and March 20th, Dr. Rowe gave us his opinion that anemia was a factor in four deaths out of that 36?

7

A. Yes.

8

9

Q. Would that surprise you or not?

10

11

12

13

14

15

A. Well, this again, one would have to look up the individual cases, but it would sort of confirm as being relatively rare.

16

17

18

19

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Q. What I am getting at is, you have said it is relatively rare, my friends are already going ah-ha-ha, I am simply saying to you that Dr. Rowe judged it to be a factor according to his chart in four out of 36 cases. Is that consistent with your expectation?

A. Yes, I would think so.

Q. Yes. Now, the last cause, everyone will be delighted to hear, that Dr. Rowe



1

2 assigned was the Di George Syndrome. I take it you
3 would expect to find evidence of that at autopsy?
4

A. Yes, that is correct, yes.

5 Q. Well now doctor, can I take
6 you back to the Pacsai case. You have told Miss Cronk
7 that this was a case in which the coroner asked you
8 to perform an autopsy?

A. That is correct.

9 Q. And he sent you the warrant
10 which I take it is already an exhibit?

A. Yes.

11 Q. And you can't commence the
12 autopsy without the physical receipt of the warrant?

A. That is correct, yes.

13 Q. Now, I won't get it out, but
14 I know you remember it, was there anything in that
15 warrant which the coroner invited you to do or
16 suggested you might do or wanted you to look at
17 matters relating to digoxin?

A. No, he did not.

18 Q. So I take it when you got
19 the coroner's warrant - he's the boss, isn't he?

20 A. Well, he would direct the
21 investigation, yes.

22 Q. And he did not direct your

23

24

25



1

attention to anything connected with digoxin?

6

A. That is correct, yes.

3

Q. Indeed, he directed your
attention to something altogether different, that
was potassium?

4

A. That is correct, yes.

5

Q. And I take it you reviewed
the chart, as you have told us and told Miss Cronk?

6

A. Yes, I did.

7

Q. And that you found there
two notes I think made by Dr. Costigan about digoxin,
the therapeutic reaction to digoxin?

8

A. Yes, that is correct.

9

Q. And was it that and that
alone which led you to do the serum level?

10

A. Well, I think the digoxin
adverse effects in combination with low potassium
would be a significant finding.

11

Q. Yes. The question I am
getting at is, I take it, did the warrant direct
you to digoxin?

12

A. No, it did not.

13

Q. All right, it was the chart
that directed you to digoxin?

14

A. That is correct, yes.

15

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17



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Q. And that was the two references

3 in the record?

4

A. Yes.

5

Q. To digoxin?

6

A. Yes.

7

Q. About which we have heard?

8

A. Yes.

9 Q. All right. Now, Dr. Costigan
10 gave evidence about those notes at Volume 45, page
11 121 and at line 19 - well, I will begin with the
12 question and I want you to listen to his question
13 and answer and then I am going to ask you a question
14 about it.

15 "Q. All right. In the Pacsai case you
16 wrote on the chart that digoxin toxicity
17 was one of the possibilities that you
18 were concerned with both during life
19 and I gather after the arrest of Baby
20 Pacsai. Certainly during life were you
21 thinking about digoxin toxicity as a
22 therapeutic or as a response to a
23 therapeutic dose."

24 And here is his answer:

25 "A. Yes. What I was really considering
26 was a relatively mild degree of
27 digoxin toxicity as opposed to a



1

2 "digoxin poisoning or very excessive
3 level of digoxin. I was more thinking
4 of what might happen if renal
5 function was poor or there was some
6 other problem, the dose was a little
7 much for the baby's ability to handle.
8 You know, I wasn't thinking of any-
9 thing more."

10 Now, when you looked at the chart and
11 saw Dr. Costigan's note did you understand his note
12 in the same way he has described it to this Commission?

13 A. Yes, I did, exactly the same
way.

14 Q. So, you were not expecting
15 any toxicity in that sense, you were expecting a
16 reaction to a therapeutic dose?

17 A. Yes.

18 Q. Yes. Would it be fair to
19 say that, like Dr. Costigan, when you decided to do
20 the serum level, you were fairly anticipating a mild
degree of digoxin toxicity?

21 A. Yes.

22 Q. And there had been, am I
23 correct, that there had been nothing of which you were
24 aware in the Hospital prior to that time that led you

25



1

9 2 to expect anything else?

3 A. That is correct.

4

Q. And you did the autopsy,

5

I think you have said on the 13th?

6

A. Yes.

7

Q. And you sent away the viral
slides for examination or the viral tissues for
examination?

8

A. Yes.

9

Q. And you sent away the serum
level?

10

A. Yes.

11

Q. Yes. Now, did you hear about
the serum level for digoxin on the 18th?

12

A. Yes, I did.

13

Q. And can you tell the
Commission who you heard about it from?

14

A. The first I heard was from
Dr. Costigan who phoned me and told me that a high
level of digoxin was found in the postmortem sample
which I sent and a similar level was also found in
the sample he sent.

15

Q. All right. Now, did he give
you the numbers at that time?

16

A. I'm not absolutely sure

17

18

19



1

10 2 whether he did or not but I learned of the numbers
11 3 during the same day.

4

5 Q. Now, to be fair to him, Dr.
6 Costigan doesn't recall this conversation in which he
7 told you about his reading and the serum level that
8 you had obtained. Does that alter your view as to
9 whether you discussed it with him?

10

11 A. No. I am absolutely sure
12 that he did phone.

13

14 Q. He's a little hard to mistake
15 isn't he, when you get a call from him?

16

17 A. Well, I didn't hear of Dr.
18 Costigan before that phone call and shortly there-
19 after I made notes about the events.

20

21 Q. All right.

22

23 A. And I'm quite sure that he
24 did phone.

25

26 Q. All right. Then I take it
27 very shortly after that Dr. Fowler came down to look
28 at the record?

29

30 A. That is correct, yes.

31

32 Q. And did Dr. Fowler tell you
33 that he had heard about the readings in Pacsai?

34

35 A. Yes, he did.

36

37 Q. And did he tell you that he

38

39



1
11 had been to see Dr. Carver about them?

2
3 A. No, he didn't tell me directly
4 that he went to see Dr. Carver but he said that he
5 needs to review the chart looking at the administration
6 of digoxin in this infant and that this case is
7 going to be reviewed by the Hospital Incidence
8 Committee.

9 Q. Dr. Fowler gave evidence
10 here that Dr. Carver asked him to do an investigation
11 about the digoxin reading which had by then been
12 obtained on the Pacsai baby. Did he see anything
13 that indicated that that investigation was underway
14 and he was doing it?

15 A. No. I wasn't aware that
16 he was in charge of the investigation. I only knew
17 that he wanted to review the records.

18 Q. All right. Did he tell you
19 that the coroner had already been notified about the
20 readings?

21 A. Yes, I think so. I'm not
22 absolutely certain but I think he mentioned that the
23 coroner was notified.

24 Q. All right. Well now, when
25 you heard about the readings did you form any opinion
as to what they might mean?



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A. Well, my immediate reaction was that it was so unbelievably high that I was thinking of some kind of an error either in the test and/or error in administration.

Q. All right. Well now, can you tell me, Doctor, when you in fact received back the serum reading on Baby Pacsai?

A. The actual report I think was received on the 24th.

Q. All right. Now, I have searched this out and subject to my search would it be fair to say that the bacteriology report was available on the 20th?

A. Yes.

Q. And the virology report was available on the 13th of April?

A. Yes, that is correct.

Q. So that having done the autopsy on the 13th, having heard from Dr. Costigan about the reading, I take it you were still waiting for these three formal reports before your report to the coroner could be made up?

A. That is correct.

Q. Now, when Dr. Costigan came and told you about this reading, and you subsequently



13

1 had the discussion with Dr. Fowler, did you believe
2 that the coroner had been notified of the reading?

3
4 A. Yes, I did.

5 Q. Yes. Was there anything else
6 that you could have done at that stage to analyse
7 the cause of this death?

8 A. No, I don't believe so.

9 Q. All right. Now, we have
10 heard evidence that on the Sunday the police came to
11 the Hospital?

12 A. Yes.

13 Q. And that in a meeting on the
14 Monday you were asked to hurry up your autopsy report
15 for the coroner on the Pacsai baby?

16 A. Well, I believe that was
17 during the Tuesday meeting.

18 Q. All right. Now, can you
19 tell us what you provided to the police at that
20 stage?

21 A. Well, I provided the notes
22 which I had available at that time which were in-
23 complete.

24 Q. Yes. And those notes would
25 be on a form called Interim Pathological Report?

A. Yes, a preliminary report.



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Q. Yes. But the notes that

you provided were not the autopsy report, they were simply on that sheet, am I right?

A. That's right, yes.

Q. Did you also provide a copy of your report to the coroner?

A. Well, the actual complete coroner's report was issued in April.

Q. I understand that.

A. Yes.

Q. But did you provide them with something on the form of a coroner's report?

A. Yes, I provided the form which was partially completed and included the gross findings.

Q. Yes. Do you have a copy of that with you?

A. Yes.

Q. Now, you have provided for me a six-page report. I take it this report is on the form that would normally be utilized when you make your ultimate report to the coroner?

A. That is correct, yes.

Q. And this form is the one you provided and gave to the police?



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15 2 A. Yes, I gave this form,

3 plus I gave my notes which were in a different form.

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D/EMT/ak 3 MR. SCOTT: Well, perhaps if this is
4 what you gave to the police we can have it marked
as an exhibit.

5

6 THE COMMISSIONER: Can I just see it
7 for a moment because it may be the same - I think it
is the same, is it not, as 106A? No, it isn't.

8

9 MR. SCOTT: I think it is not,
10 Mr. Commissioner. 106A is --

11

12 THE WITNESS: No, it is just partially
13 filled out.

14

15 MR. SCOTT: All right.

16

17 MS. CRONK: Can I see it?

18

19 THE COMMISSIONER: Yes.

20

21 What number do you want to make it?

22

23 MR. SCOTT: The next number.

24

25 MS. CRONK: I suggest 106B.

MR. SCOTT: All right.

THE COMMISSIONER: Can we do that?

18

19 MR. SCOTT: That is fine.

20

21 THE COMMISSIONER: 106B then.

22 ----EXHIBIT NO. 106B: Six-page document entitled
23 "Report of Postmortem
24 Examination".

25 THE COMMISSIONER: How do you describe
that, Doctor? How do you describe that document?



D2

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2

THE WITNESS: It was a partial --

3

4

MR. SCOTT: Well, it is a form
provided for your coroner's report, isn't it?

5

THE WITNESS: That is correct, yes.

6

7

8

THE COMMISSIONER: We already had one
and I was just wondering how we could distinguish
this because we have one already, the final autopsy
report.

9

MR. SCOTT: Well, the distinguishing
feature it seems to me is the date. The final
autopsy report made to the coroner would not have
been made until late April I think.

10

11

12

THE WITNESS: That is correct, yes.

13

14

THE COMMISSIONER: And this one is?

15

16

MR. SCOTT: The Tuesday.

17

18

THE COMMISSIONER: Yes.

19

20

MR. SCOTT: Q. Now, what I want to
get from you, Dr. Cutz, is when you filled in this
Exhibit 106B I take it that you put down, no doubt as
a good pathologist should, everything you knew about
on the date you made the report?

21

22

23

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A . That is correct, yes.

21

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24

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Q. And of course on the report
there was no evidence of bacteriological, virological
or digoxin readings because those hadn't yet come back?



D3

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A. Yes.

2

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THE COMMISSIONER: Sorry. Wait a second. You say this was given on the 24th. I thought you said the bacteriology report you had on the 18th of March. Have I got that wrong?

4

5

6

MS. CRONK: The 28th of March, sir.

7

8

MR. SCOTT: Let's see. Did you put down in here the bacteriological report?

9

10

11

12

THE WITNESS: No, I think - you see I gave this which was partially filled out and then I gave a report which is I guess a preliminary which is on a hospital form.

13

14

MR. SCOTT: Q. I will be coming to that in a moment.

15

A. Yes.

16

17

18

Q. Dealing with 106B is there a place on this form to put down any bacteriological material that had been returned with readings from the lab?

19

20

A. Yes. That would be on page 5 under Section 5.

21

22

Q. And you have set nothing out there?

23

24

A. No.

25

Q. All right. I take it with



D4

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respect to virology and digoxin you yourself had
not received any reports back?

3

A. No. I had a verbal report
on digoxin but no actual...

4

5

Q. Report?

6

7

A. Report, yes.

8

Q. And therefore it is not shown
in Exhibit 106B?

9

A. Yes.

10

11

Q. And the verbal report you had
came in the way you have described from Dr. Costigan?

12

A. Yes.

13

Q. And later was confirmed by
Dr. Ellis?

14

A. That is correct.

15

16

Q. But the report was not at hand
as yet?

17

A. No, it wasn't.

18

19

Q. Now you say you provided also
your own notes to the police and do you have a copy
of those?

20

21

A. Yes. I think that is part of
the exhibit I believe.

22

23

Q. If you get it out and show it
to me I can... Now these notes appear on a form

24

25



1

2

called Preliminary Autopsy Report, Hospital for
Sick Children.

4

A. Yes.

5

6

Q. I take it that this report
would not normally be prepared because you are doing
a coroner's report?

7

A. That is correct.

8

Q. And you are simply using this
notepaper to make your own notes?

9

A. That is correct.

10

11

12

13

Q. And you would anticipate
transferring what is in this note to the formal
autopsy report which is made in April?

14

A. Yes.

15

16

17

Q. So when we see this headed
Preliminary Autopsy Report we should not understand
this to be an autopsy report because you were doing
an coroner's autopsy, weren't you?

18

A. Yes.

19

20

Q. You were just making notes
here?

21

22

23

A. Yes. This was just provided.
as an information to the police.

24

25

Q. Yes. All right. I think that
may be in.



1

2

MS. CRONK: I have never seen it.

3

4

THE COMMISSIONER: Well, if this is -
may I see it because it may well be the same
document. Is that entitled "Preliminary Autopsy
Report"?

5

6

MR. SCOTT: Yes.

7

8

THE COMMISSIONER: Maybe the same
document is on page 94 of the --

9

MS. CRONK: Sir, I haven't had a
chance to compare them but as you point out there is one
called Preliminary Autopsy Report on page 94 of the
medical record.

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THE COMMISSIONER: Yes. It seems to
be almost identical. In fact it does seem to be
absolutely identical. It is on page 94 of Exhibit
106.

MR. SCOTT: Q. The point I want
to make, Dr. Cutz, is when you are doing the work
for the coroner as in the case of Baby Pacsai, you
have to fill in this coroner's report?

A. That is correct, yes.

Q. It would not be normal to fill
in the preliminary autopsy report as it would be
when you were doing an in-hospital report?

A. That is correct. The only



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2

report for the coroner's case is that form. There
is no other report.

4

5

6

Q. Yes. And what appears in the
record as your preliminary autopsy report is in fact
not an autopsy report at all?

7

8

A. No, those would be my personal
notes.

9

10

Q. Yes. A copy of which you gave
to the police when they asked?

11

12

A. That is correct.

THE COMMISSIONER: How did it get in the
Hospital record notes?

13

14

MS. CRONK: I didn't put it there,
Mr. Scott.

15

16

MR. SCOTT: Well, the police had it
and I have no doubt they copied it, but this has
bedevilled us from the beginning.

17

18

19

20

MS. CRONK: Well, Mr. Commissioner,
I'm not sure that suggestion is entirely fair unless
Mr. Scott knows the police put it in the medical
record.

21

22

23

MR. SCOTT: I am not saying the
police put it in the record. I am simply saying the
police had a copy of it.

24

25

THE COMMISSIONER: Yes.



1
2 MR. SCOTT: The point I make is
3 obvious and it should be given an exhibit number.

4 MR. ORTVED: I think, Mr. Commissioner
5 just while we are on the topic it might be mentioned
6 that a great number of charts do contain things like
7 coroner's autopsy reports which I think someone more
8 expert than I will tell you in evidence would not
ordinarily be found in hospital records.

9 THE COMMISSIONER: Yes. All right.

10 MR. ORTVED: I think those reports
11 got married up with records prior to this Commission
12 sitting.

13 THE COMMISSIONER: All right.

14 What about 106C for that?

15 MR. SCOTT: All right.

16 ---EXHIBIT NO. 106C: Document entitled "The
17 Hospital for Sick Children,
18 Toronto", numbered 33471.

19 THE COMMISSIONER: You might, though,
20 Doctor, tell us if you have any recollection of just
what you did with that document?

21 THE WITNESS: This document - well,
22 the two documents, that is the preliminary reports
23 and the partially filled out coroner's report, was
given to the police I believe on the week of the --



1

2

THE COMMISSIONER: You didn't yourself
put them in the records?

4

THE WITNESS: No, I did not.

5

And later on when I completed the
final coroner's report which was in April this was
sent to the coroner's office.

6

7

THE COMMISSIONER: Yes.

8

THE WITNESS: This is the official
report so there should be only one report.

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MR. SCOTT: Q. Well, Doctor, you
have told us that when you did your work and when
you heard from Dr. Costigan and subsequently
Dr. Ellis about their readings that you believed
from what Dr. Fowler said that the coroner had
already been notified?

A. That is correct, yes.

Q. And you have told us I think
that there was nothing more you could do in pursuing
the matter?

A. That is correct.

Q. And I think you have also told
us that you still believed it to be an administration
error or a therapeutic case gone wrong?

A. No, I thought that this should
be investigated to really find out what it means.



1

2

Q. Yes. Was there anything you
could have done?

3

A. I don't believe so.

4

5

Q. All right. Well now at that
stage I take it that the possible causes of death
were digoxin because you had heard of the reading
from Dr. Costigan?

6

7

A. Yes.

8

9

10

Q. Potassium because there was
an elevated reading of potassium?

11

A. Yes.

12

13

Q. Was it congestion or conduction
failure?

14

15

A. No, they were findings of
congestion in various organs.

16

17

Q. All right. Then I had it
right. And I take it that the potassium reading
is a highly elevated potassium reading?

18

19

A. Well, the postmortem potassium -

Q. That is what I meant.

20

21

22

A. -- would be high for a living
person but in the post mortem I don't think it is
of great significance.

23

24

25

Q. Well, you are telling us some-
thing that comes from your understanding of what the



1

2

pharmacologists say that a high potassium reading
that would kill in life is discounted because the
pharmacologists tell you that it is created after
death?

6

A. Yes.

7

Q. Isn't that right?

8

A. That is correct.

9

Q. So if this reading had been

obtained some years ago you might have said this
potassium would kill?

11

A. Yes, you might have, yes.

12

Q. But the pathologists don't
do it, but the pharmacologists have said don't be
misled by that potassium reading because it is
created post mortem from a perfectly normal potassium
level?

16

A. Yes.

17

Q. And that is how you exclude
potassium?

19

A. Yes.

20

Q. I take it you then have
congestion and digoxin?

22

A. Yes.

23

Q. And you wanted to make a
choice between those two if possible?

24

25



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A. Yes.

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6

Q. And I take it that you told me the other day that you had no formal or little pharmacological knowledge about the operation of digoxin post mortem?

7

A. Yes.

8

9

Q. But you assumed that it was a real reading in the sense that the postmortem figure disclosed what existed at death?

10

A. Yes.

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Q. And I suggest to you, Doctor, that you selected digoxin, and the baby may have been killed by digoxin - don't misunderstand me; I am not saying there were no murders here - but the reason you selected digoxin was because if you selected congestion it would not explain what you believed to be a high digoxin reading?

A. That is correct.

Q. So confronted by the two

remaining choices there is only one to select. Am I right?

A. Yes.

Q. And that was based entirely at that time on what you knew about the operation of digoxin following death?



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2

A. Yes. What I knew, plus I consulted with biochemists and clinicians, and that was a consensus, at least on the knowledge that this was an abnormal reading.

6

7

Q. I am not suggesting to you that you did anything wrong. I am simply saying - did you consult with any pharmacologists?

8

9

A. Yes, I did.

10

Q. Who was that?

11

A. Dr. MacLeod.

12

13

Q. Yes. And he gave you the traditional wisdom in March of that year on digoxin?

A. Yes.

14

15

16

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18

19

Q. Now let me put this proposition to you: if - it may not be; it will be for the Commissioner to decide - but if there is a possibility of explaining that digoxin reading and neutralizing it by making it innocent as you have done with potassium, I take it then you go to congestion as the cause of death?

20

21

22

23

A. Well, congestion in this case it would only indicate that there was heart failure in this patient, but I don't think we can really consider it as an immediate cause of death.

24

25

Q. Let me put it to you this way:



1

2

if the pharmacologists persuaded you that that
digoxin reading was not to be taken at face value -
they maybe would persuade you and maybe they won't -
but if they did, then what is the cause of death in
this case?

7

A. Well then we would have to

call it anatomical cause of death undetermined.

8

Q. All right. In other words,
it may have been caused by congestion or a conduction
failure?

11

A. No, I think then it might have
been caused by what one generally could call heart
failure.

14

Q. All right.

15

A. Of undefined origin.

16

Q. I think you told Miss Cronk
in chief that on Friday, March 20th --

17

A. Yes.

18

Q. -- you passed Dr. Mancer's
office and went in to see him?

20

A. Yes.

21

Q. And that on that occasion
you told him about what you had heard from Dr. Costigan
and Dr. Ellis about the reading in the Pacsai serum
test?

24

25



1

A. Yes, I did.

2

Q. I take it that you presented
that to him as a phenomenon of interest as between
pathologists?

3

A. That is correct, yes.

4

Q. And I think you mentioned to
him another case a year before where there had been
a prescription error?

5

A. Yes, I did.

6

Q. Did you mention that case in
connection with the digoxin reading?

7

A. Yes. I mentioned that case
in that particular instance there was a decimal
error made in the prescription.

8

Q. Yes. And that is the Yuz,
Y-u-z, case?

9

A. That is correct.

10

Q. And it was ascertained that
there had been a prescription error, a decimal error
so-called?

11

A. That is right.

12

Q. And you mentioned that to
Dr. Mancer in connection with your finding or what
you had heard about the finding in Pacsai?

13

A. Yes. As I said I didn't know

14

15



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exactly what this level meant, and I thought that
it perhaps could be explained on a similar basis as
the previous case.

5

Q. All right.

6

A. There might have been a decimal
error in prescription.

7

Q. And at the moment when you
went into Dr. Mancer's office was that still your
view?

10

11

12

A. Yes. I basically went to ask
him and consult him if he had any experience with
postmortem digoxin.

13

14

Q. And did he at that time tell
you about Estrella?

15

A. Yes, he did.

16

17

Q. Did he know at that time from
what you heard from him that Pacsai was a coroner's
case?

18

A. No. I told him.

19

Q. You told him?

20

A. Yes.

21

22

23

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Q. Well now when you heard about
Estrella and put it together with what you had
heard from Dr. Costigan about Baby Pacsai, what then
was your reaction as to how it had happened?



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A. Well, Dr. Mancer mentioned this case - I can't recall if he mentioned the name but he says he has a case where there is an even higher level than in my case, and his interpretation at the time was that to him this looks like a lab error of some kind and they did not believe this to be a true result.

Q. Well, the question I am asking you is when you heard him report to you about the other case, what then was your reaction putting the two cases together?

A. Well, this conversation came after I had spoken to Dr. Ellis who assured me that the test in Pacsai was valid and there was no lab error so now hearing from Mancer that his result was considered a lab error I was a bit puzzled which I would think that in Dr. Mancer's mind it might have triggered a different reaction than it did in mine.

Q. Yes. But he told you it was a lab error?

A. Yes, that is what they were thinking that was, yes.

Q. Well, as a result of that conversation was your concern about Baby Pacsai increased, decreased or left at the same level?



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2

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A. No, I think that would

definitely increase that there must be some problem
with digoxin, either something we don't know what is
happening or there is some problem on the ward.

6

7

8

Q. All right. Now following
that did you resolve in your own mind to do anything
if there were further autopsies as there might have
been in the future?

9

10

A. Yes. As a matter of fact I

did, yes.

11

12

13

Q. And what did you resolve to do?

A. Well, as it happened I was on
call for the weekend following that conversation --

14

15

Q. I will be coming to the
events in a minute. I just want to get from you
if I can --

16

A. Yes.

17

18

Q. -- what you decided in your

own mind to do?

19

20

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A. I thought it would be one way

to perhaps look into the question what happens
with digoxin post mortem is to do some more measure-
ments in those patients who received digoxin in life
and compare them with patients who did not.

Q. All right. Now what did you



1

2

conclude therefore that you as a pathologist would
do?

4

5

A. Well, that I would send the
samples for analysis there in future cases.

6

7

Q. All right. And you were on
duty that weekend?

8

9

A. Yes, I was.

Q. And I take it that on Saturday

10

there were three or four autopsies to be done?

11

12

A. Yes, that is correct.

Q. And one of them we now know

13

was the autopsy on the Baby Miller?

14

15

A. Yes. Correct.

Q. And this was not a coroner's

16

case?

17

18

A. No, it was not.

Q. And I take it it was therefore
a case where Dr. Taylor, the resident, would do the
autopsy under your supervision?

19

20

21

22

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DM/cr

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Q. Now I think you have told us that it was your practice in those cases to allow the resident to read the record before doing the autopsy?

A. That is correct.

Q. And then you would discuss the record with him before the autopsy was done?

A. That is correct.

Q. Before the autopsy was commenced?

A. Yes.

Q. Now when you discussed the matter with Dr. Taylor before the autopsy was commenced, did you ask him to do something?

A. Yes. I believe, I told him that it would be interesting, or I asked him to take some blood samples for digoxin measurement.

Q. Can I stop you there just for a minute.

A. Yes.

Q. Was there anything in the record, or was there anything you had heard about the record that pointed to any digoxin implication in the case?

A. No, I don't believe so.

24

25



2

1
2 Q. Why were you asking Dr. Taylor
3 to do a serum level for digoxin then?

4 A. This was in light of the
5 findings I knew at the time with the Pacsai baby,
6 and then what I learned from Dr. Mancer on Estrella.

7 Q. Was this part then of your
8 experiment?

9 A. That is right.

10 Q. To get more postmortem readings?

11 A. That is correct.

12 Q. And what did Dr. Taylor tell
13 you?

14 A. Dr. Taylor told me that as
15 a matter of fact he had already been asked by the
16 clinicians to take a blood sample for digoxin.

17 Q. All right. Now can you tell
18 me when that sample came back to the Pathologists
19 Department?

20 A. I had not heard about the
21 results until the next week. This would have been
22 taken on Friday and I am not exactly sure about the
23 date, but it was in the week of - between the 23rd
24 and the 26th.

25 Q. After the police came in?

A. That is correct.



1

3 Q. And I take it that you were
2 doing an autopsy yourself that day?
3

4 A. That is correct.
5

Q. On a SIDS baby?
5

A. That is correct.
6

Q. Or a baby whose cause of
7 death was ultimately assessed to be SIDS?
8

A. That is correct.
9

Q. And did you take a postmortem
10 digoxin level there?
11

A. Yes, I did.
12

Q. And was that again part of
13 your experiment to find out more, if you could, about
14 postmortem levels of digoxin?
15

A. That is correct, yes.
16

Q. Was there any evidence in the
17 SIDS baby's case that digoxin had anything to do with
it?
18

A. No, the baby died I believe at
19 home and it was unlikely that he would have received
20 digoxin.
21

Q. Would it be correct to say
22 that after you talked with Dr. Mancer you determined
23 that on every baby that went through your autopsy
process you would do a postmortem digoxin serum level
24
25



1

4 2 in order to find out what you could about the re-
 3 action, about those post serum levels, postmortem
 4 levels?

5 A. Well at that stage we really
 6 didn't have a mind to do an extensive study, but I
 7 think the events following that, the actual suggestion
 8 to do these levels in all the cases was made by Dr.
 9 Bennett.

10 Q. Did you do the levels on all
 11 the cases on Saturday?

12 A. Not only on the two cases?

13 Q. Yes.

14 A. Yes.

15 Q. But on the others?

16 A. I can't remember whether we
 17 did or not.

18 Q. But that was something you
 19 decided to do?

20 A. That is right.

21 Q. That is before Dr. Bennett
 22 got into the picture?

23 A. That is right.

24 Q. Well now ---

25 THE COMMISSIONER: Just so that I
 26 have it clear. The SIDS baby I take it you did take



1

2 a test for digoxin?

3

THE WITNESS: Yes.

4

THE COMMISSIONER: And none showed up?

5

THE WITNESS: That is correct.

6

MR. SCOTT: Q. And the SIDS baby
would have been the second digoxin serum level you
had ever taken in your life?

7

A. That is right.

8

Q. Now the following day was a
Sunday?

9

A. Yes.

10

Q. Just to complete this; and
do I have it that by Saturday night, while you were
concerned, there was no reason to believe that there
was any sinister events under way in the Hospital?

11

A. No. At that point I was aware
that the coroner had been notified and that the
Committee in the Hospital is investigating the matter
of digoxin, but I had no other concerns.

12

Q. And the only sample, apart
from Estrella's that you had, was Pacsai?

13

A. That's right.

14

Q. And the Miller sample wasn't
back to your knowledge yet?

15

A. No, it was not.

16

17



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6 Q. Well then on Sunday morning
2 you got a call, that I think you described in chief,
3 from Dr. Fowler?
4

5 A. Yes, that is correct.
6

7 Q. Did he give you any information
8 as to whether the coroner was aware of the death of
9 Baby Cook upon whom the autopsy was to be performed?
10

11 A. Yes. I actually asked him
12 whether this case had been cleared by the coroner.
13

14 Q. And had the coroner been
15 notified?
16

17 A. To my understanding, yes,
18 Dr. Fowler said he had.
19

20 Q. Were you requested to do a
21 coroner's inquest, had the coroner taken charge or was
22 it to be a Hospital inquest?
23

24 A. No, it was a Hospital inquest.
25

26 Q. I take it you did not receive
27 from the coroner any warrant requiring you to do an
28 autopsy on Cook?
29

30 A. No, I did not.
31

32 Q. And I take it that Dr. Taylor
33 did the autopsy?
34

35 A. Yes, that's correct.
36

37 Q. And that you reviewed the
38

39

40



1

2 record with him?

3

A. Yes, that's correct.

7

4

Q. And you made that review
5 before the autopsy began?

6

A. Yes, that is correct.

7

Q. And would it be fair to say
8 that the record showed Cook to be a very sick baby?

9

A. Yes.

10

Q. Would it also be fair to say
11 that the record did not show anything that would
12 alert one to digoxin as a factor in death?

13

A. No, I don't believe so.

14

Q. And I take it that - was it
15 before the autopsy began or during the autopsy that
16 Dr. Fowler came down to the autopsy room?

17

A. Well Dr. Fowler phoned me
18 early in the morning at my home.

19

Q. That was to get you up to go
20 down to the Hospital?

21

A. Yes, but the reason he told
22 me that he is phoning me is to say, to make sure that
23 we take sufficient samples of blood for digoxin
determination, and this is when I had the conversation
with him regarding whether it was or it was not a
coroner's case.

24

25



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2 Q. Did he come down, either
3 before or during the autopsy?

4 A. No, he came down personally
5 to the autopsy suite during the autopsy.

6 Q. And I take it that at that
time he advised you about the pre-mortem serum levels?

7 A. Yes, he did.

8 Q. You had no previous knowledge
9 of that until he told you?

10 A. No, I did not.

11 Q. And I take it that that very
much alarmed you?

12 A. Well when he mentioned that
13 this baby had a high digoxin reading and was not
14 prescribed the drug that was obviously a very serious
15 situation.

16 Q. And when you say he described
17 the high digoxin reading, he was of course talking
18 about an in vivo reading?

19 A. That is correct, yes.

20 Q. Was it then that you elected
21 to take a large sample and to provide half of it to
your own labs and half to the Forensic ---

22 A. That is correct.

23 Q. The Forensic Division of the

24
25



1

2 Attorney General's Department?

3

A. That is correct, yes.

4

Q. And I take it that you delivered
5 their sample over to them personally?

6

A. That is correct.

9

MR. SCOTT: Those are all the questions
7 I have for you, Dr. Cutz. Thank you.

8

THE COMMISSIONER: Thank you. Mr.
9 Ortved?

10

MR. ORTVED: No questions thank you,
11 Mr. Commissioner.

12

THE COMMISSIONER: Mr. Brown?

13

MR. BROWN: I have no questions, Mr.
14 Commissioner.

15

THE COMMISSIONER: Miss Forster.

16

MISS FORSTER: Thank you, Mr.

17

Commissioner.

CROSS-EXAMINATION BY MS. FORSTER:

18

Q. Doctor, I take it on autopsy
19 you have had occasion to see cases where it is
20 difficult to determine the exact cause of death?

21

A. Yes, that is correct.

22

Q. And I also take it that you
23 may find a person suffering from a number of
24 conditions any one of which could push the person

25



10

1 over the brink?

3 A. That is correct, yes.

4 Q. And in that situation it may
5 be possible to determine that a person died of natural
6 causes without being able to pinpoint the exact
7 cause, is that correct?

8 A. Yes. If we are dealing with
9 the Hospital population and patients who have a known
10 disease, then I think we always deal with natural
causes, yes.

11 Q. Now, I want to take you to
12 your evidence on Pacsai, Doctor, and at Volume 42,
13 page 8548, Miss Cronk asked the following questions:

14 "Q. Was there in your mind, Doctor,
15 at the time that you took the sample
16 any risk of contamination from either
17 artefacts surrounded the sample site
18 or from any other materials that were
then evidenced?"

19 A. Well, not in terms of contamination
from other sources, no."

20 Do you recall being asked that
21 question and giving that answer?

22 A. Yes, I do.

23 Q. Can you tell me, Doctor, what

24

25



Cutz, cr.ex.
(Forster)

1

11 2 you meant by the words "contamination from other
3 sources"?

4 A. Possibly another type of
5 contamination may be, a bacterial contamination,
6 which sometimes does happen even with the most careful
7 precautions.

8 Q. Where does that bacterial
9 contamination come from?

10 A. It comes from the surrounding
11 air.

12 Q. Is that a kind of contamination
13 that can happen in any sample taking situation?

14 A. Well this would be a
15 contamination if you do cultures, for instance, if
16 you do bacterial cultures and sometimes you can get
17 a contamination from this source.

18 Q. And how would that come about?

19 A. Well once you open the body
20 you expose it to the external air, especially in the
21 autopsy room it would be full of all kinds of
22 organisms, then they would settle on those tissues
23 from which you obtained the sample.

24 Q. And do you know whether or
25 not the sample has been contaminated by substances
in the air?



1
2 A. Well in this instance the
3 bacterial culture was negative, in other words nothing
4 was grown so it was not contaminated.

5 Q. Is it only through doing a
6 bacterial culture that you know whether a sample has
7 been contaminated by the air?

8 A. Well, this would only refer to
9 the bacterial contamination. I thought what Miss
10 Cronk was referring to was contamination by other
11 body fluids, or tissues which I don't think was the
12 case.

13 Q. But I take it apart from the
14 contamination by other body fluids there are other
15 types of contamination that can happen?

16 A. That is correct, yes.

17 Q. And can some of those types
18 of contamination happen without the knowledge of the
19 pathologist doing the autopsy?

20 A. Yes, that is correct.

21 Q. Now dealing with Baby Miller,
22 Miss Cronk asked you about the autopsy report in
23 Volume 44, page 8942, and at page 8942 at the bottom
24 Miss Cronk was reading to you a portion of the
25 autopsy report and she says:

"If we keep reading, Doctor, do we



1

13 "see also:

2
3 'All cardiovascular and respiratory
4 pathologic changes are considered
5 chronic.'

6
7 And then this sentence:

8
9 'Immediate cause of death is digoxin
10 toxicity.'

11 A. Yes.

12 Q. I take it that was your opinion
13 at that time?

14 A. Yes."

15 Doctor, is there any significance in
16 the use of the words "at that time"?

17 A. Yes, there is.

18 Q. Can you explain yourself
19 please.

20 A. Well the report was prepared,
21 as I mentioned before, during a very unusual period
22 in the Hospital where all these tests were under
23 police investigation and we were asked to provide
24 the information on these autopsies in a rather
25 hurried way.

Q. Yes.

A. And one is faced with
23 interpreting these abnormal digoxin readings in the

24

25



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2 context of say natural disease in the patient. In
3 such an instance this reading would override any other
4 findings you had.

5

Q. Is that still your opinion
today?

14

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A. Well, I think we seemed to
learn a little bit more about postmortem digoxin but
it is still hard to explain some of these readings,
so I have no definite opinion.

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Q. In your opinion is this a
case, such as the Pacsai case that Mr. Scott asked
you about, in which you defer to the opinion of
the pharmacologists as to the significance of
digoxin levels?

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A. Yes. I think what the
pharmacologists point out is that the reading
at post mortem depends on many factors. For example,
the last dose administered prior to death; then any
organ failure in the system in which the digoxin
has been eliminated; then possible release of
digoxin from tissues post mortem. So there are
numbers of factors which could account for an increased
level post mortem, yes.

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Q.

Now in giving your opinion on
the Miller baby, were you giving that opinion based



DM E
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15 2 solely on the information you had as to the digoxin
3 level in that baby?

4 A. Yes, I did.

5 Q. With respect to Baby Cook, I
6 take it that autopsy was restricted to the heart and
7 lung only, is that correct?

8 A. That is correct, yes.

9 Q. And I take it that the
10 conclusion you reached in the autopsy report was
11 based solely on your examination of the heart and
12 lung, and any information you had about digoxin
13 levels?

14 A. That is correct, yes.

15 Q. And would you agree with me,
16 Doctor, that had you been able to conduct a full
17 autopsy on that baby that full autopsy may have
18 disclosed other possible causes of death?

19 A. Yes. One might find some
20 other anatomical or other findings, yes.

21 Q. And Miss Cronk asked you about
22 your conclusion in the Cook autopsy at Volume 44,
23 page 8990:

24 "Q. Doctor, once again at page 2 of
25 the final autopsy report, the con-
clusion is drawn and recorded that



(Forster)

1
2 "digoxin toxicity is the immediate
3 cause of death. I take it that was your
4 opinion at the time the final autopsy
5 report was prepared for your
6 signature?

7 A. That is correct."

8 Doctor, again the words "at the time"
9 are used, is there any significance to those words?

10 A. Yes. It means, referring to
11 the same period of time which all these cases have
12 been dealt with.

13 Q. And is your opinion with
14 respect to the Cook cause of death subject to the
15 same qualifications as Miller and Pacsai, in that
16 you defer to the opinion of pharmacologists?

17 A. Well this is a different
18 situation, because to my knowledge the Cook baby was
19 not prescribed digoxin. So we cannot explain then how
20 you get digoxin reading in a patient who does not
21 get digoxin, or not supposed to get it.

22 Q. Would your opinion with
23 respect to Cook, was it any different at the time you
24 prepared the autopsy report than it is today?

25 A. No. I think that was probably
26 the most definite kind of a case if one was to think



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of some sinister happenings, yet providing an
accidental administration of drug has been ruled out.

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Q. Again, Doctor, would you defer
to the opinion of pharmacologists as to the
significance of those readings?

17

A. Yes, I would.

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Q. And was your opinion based
solely on the information you were given as to the
digoxin levels in that baby?

10

A. That is correct.

11

MS. FORSTER: Thank you, Doctor.

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THE COMMISSIONER: I think we will
take 20 minutes.

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---Short recess.

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2 --- Upon resuming:

3 THE COMMISSIONER: Yes, Mr. Hunt? Oh,
4 I'm sorry, oh, yes, Miss Cecchetto.

5 CROSS-EXAMINATION BY MS. CECCHETTO:

6 Q. Now, Dr. Cutz, you told us that
7 in respect of the Pacsai case that was a coroner's
case that was referred to you?

8 A. That is correct, yes.

9 Q. And you indicated that prior to
10 the gross autopsy and based on your review of the
11 chart and your discussion with Dr. Fowler, you found
12 that the case was a puzzling one?

13 A. Yes. It was in that there was
14 no definite clinical diagnosis, plus there was this
15 unexplained fluctuation in the potassium levels, yes.

16 Q. So, at the time there was
17 nothing to suggest an immediate cause of death simply
18 prior to gross autopsy. You didn't have any immediate
cause of death?

19 A. Well, that was my understanding
20 that it was unexplained from a clinical point of view,
yes.

21 Q. And you indicated to Miss Cronk
22 last week that you had four possibilities in mind
23 before you started your autopsy and those possibilities

24

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2 were infection, a conduction system problem, digoxin
3 toxicity and potassium toxicity?

4 A. Yes.

5 Q. And you indicated further that
6 after the autopsy you ruled out all but two causes
7 of death and you were left with a concern about the
8 conduction system, is that correct, and digoxin
9 toxicity?

10 A. Yes. I think there are two
11 issues; one is as to what is the immediate cause of
12 death and the other one is what was the disease or
13 problem prior to the child arriving at our Hospital.
14 Like, the child obviously had numbers of problems and
15 it was to correlate as to how could one explain all
16 these abnormalities the child had.

17 Q. But at the conclusion of the
18 autopsy you had a concern with respect to those two
19 areas?

20 A. Yes, that is correct.

21 Q. Doctor, you indicated that on
22 the autopsy you found no problems with the adrenal
23 glands whatsoever, that they were normal?

24 A. Well, they appeared normal, yes.

25 Q. And your autopsy report, which
26 is Exhibit 106A, Doctor, doesn't suggest that you



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2 suspected that to be related to the adrenal glands?

3 A. No, I did not, no.

4 Q. Doctor, similarly, it doesn't
5 suggest that you suspected a transient adrenal
6 insufficiency to have any part in the death of this
7 child?

8 A. Well, this was brought up by
9 Dr. Bain much later during the analysis of the
10 individual cases and this diagnosis to my knowledge
11 is not mentioned in the clinical chart.

12 Q. Well, Doctor, to be fair then
13 in your discussions on the Pacsai case you discussed
14 the case with Dr. Fowler, discussed the case with
15 Dr. Ellis, Dr. Rowe was interested in the case. Did
16 any of these doctors ever come to you and suggest
possible transient adrenal insufficiency as a cause
of death?

17 A. I don't recall discussing this
18 with Dr. Rowe and prior to the autopsy I had a brief
19 discussion with Dr. Fowler but subsequently we had
20 not discussed it.

(2)

21 Q. Well, Dr. Rowe indicated in his
22 testimony at Volume 17, that this was a very rare
23 condition and that he had never seen it in his
24 experience. Would you agree that it is a rare
condition, Doctor?

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A. Well, the transient adrenal insufficiency, yes, I would think so.

3

Q. Have you ever ascribed the cause of death to transient adrenal insufficiency?

4

A. No, I have not.

5

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Q. Doctor, if I understood you correctly you indicated that if the child had died from transient adrenal insufficiency you would not expect to find any pathological findings on autopsy?

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A. Well, what I said is, I am not familiar with any pathological studies of this condition which would indicate there are some specific changes in the adrenal gland. I understand this to be a clinical diagnosis in which, in order to make this diagnosis, you would have to document changes in the adrenal gland function.

Q. And at least as far as you are

aware no one ever suggested this to you prior to

March 24th, 1981?

A. No. The first time I heard about it was when Dr. Bain brought that up.

Q. And that was in the summer of '82, Doctor?

A. No, it was during this proceedings.



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Q. Oh, I see. Now, Doctor, you indicated to Miss Cronk last week that when you learned about the 26-nanogram level from Dr. Costigan on March 18th you had a discussion with him about the level, is that correct?

A. Yes, we had a brief discussion, yes.

Q. And you indicated last week that you were unsure whether or not Dr. Costigan had told you that his levels - he indicated that he had also obtained a sample and you were unsure whether he had made it clear to you whether that was an antemortem sample or a postmortem sample, is that correct?

A. Yes. I'm not sure whether he - my understanding was that it was really either immediately prior to death or shortly thereafter. So that the long post mortem interval factor was not of significance.

Q. Doctor, you indicated that on the same day you had discussions with Dr. Fowler and Dr. Ellis about this level?

A. Well, as I mentioned before, Dr. Fowler came to see me mainly for the purposes of reviewing the chart. So that I did not discuss in detail as far as what this level meant. I had some



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2 more detailed discussion with Dr. Ellis, yes.

3 Q. And is it fair to say, Doctor,
4 that your discussion centred on whether or not this
5 was a result of a lab error or a medication error?

6 A. No. Well, since Dr. Ellis is
7 the one who generated the results then the obvious
8 question to me was as to how reliable this test is
9 and if they have any problem or problems he can fore-
10 see to get this kind of an anomalous reading. The
11 other thing we discussed also was the site of the
12 sample, which I wasn't sure why he was asking me that,
13 but I indicated to him as to where the sample was
14 taken.

15 Q. Doctor, after discussing the
16 matter with Dr. Ellis, did he not assure you that as
17 far as he was concerned there was no lab error in
18 measuring this sample?

19 A. Well, to my best knowledge that
20 is what he said that they have run it several times
21 and they get the same result. So that they felt
22 confident that this is a valid reading.

23 Q. And at least from a review of
24 the Pacsai chart there was no indication that there
25 was a medication error?

A. Well, not that I could see, no.



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Q. Doctor, your autopsy had

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A. Well, it discounted it in a
sense that we didn't see any changes grossly or
microscopically which would definitely say that, yes,
there was a renal failure, but it doesn't rule out
this possibility from a clinical point of view.

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Q. Well, it is my understanding
though that the chart showed that the child was
voiding well. So, the chart didn't indicate any
evidence of renal failure?

6

7

A. I can't recollect this to the

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Q. Now, Doctor, Mr. Scott questioned
you today about your discussions with Dr. Mancer on
the 20th in respect of the Pacsai reading and you
told Mr. Scott that when you discussed the Pacsai
reading with Dr. Mancer and when he brought the
Estrella reading to your attention you became
concerned?

10

11

A. Well, concerned in the sense
that I was earlier reassured by Dr. Ellis that there
was no lab error problem and then I am told by
Dr. Mancer that they think that their result is a lab
error.

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Q. Doctor, the last day when you testified, last week, you indicated at Volume 42, page 8562, that after your discussions with Dr. Mancer ---

MR. SCOTT: Which volume?

MS. CECCHETTO: Volume 42, page 8562.

Q. You indicated to Miss Cronk that having learned of the Estrella reading from Dr. Mancer you were relieved and this tended to reconfirm that this might be a lab error. Was that a mistake when you indicated that last day because today you indicated to Mr. Scott that if anything you became more alarmed on learning of the second reading?

MR. SCOTT: I don't see that.

MS. CECCHETTO: "A. I think the information he gave me, ..." line 14,

Mr. Scott.

MR. SCOTT: Oh, yes.

MS. CECCHETTO: Q. "A. I think the information he gave me, particularly the interpretation of that result as being a lab error, reconfirmed my information that even my case must be some kind of either laboratory error or some postmortem artefact."

MR. SCOTT: He doesn't mention being relieved.



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MS. CECCHETTO: Q. Well, if I understand your evidence to date, Doctor, you indicated that you became more alarmed when you learned of the Estrella reading?

A. Well, I wouldn't say more alarmed but I would say more positive because I had this controversial interpretation and, you know, that kind of indicated to me that really not much is known about it.

Q. Now, Doctor, in your cross-examination by Mr. Scott last week, Mr. Scott asked you about the final autopsy reports in a number of cases, as did Miss Cronk. When you were asked to do the final autopsy reports in Miller, Cook and Pacsai, you were asked to do them as rapidly as possible because of the police investigation, is that correct?

A. That is correct, yes.

Q. Was it ever suggested to you though that you should not take the time that was required in order to prepare a proper report, Doctor?

A. Well, these reports were completed to a certain stage. It depended on the complexity and then on the extent of what different samples were sent to various labs and to what extent these things came back. So that some of the reports



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even may appear as final. There are notes saying
that there is still some notes pending.

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Q. But the reports represented
your best medical opinions at the time, did they not,
Doctor?

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A. That is correct, yes.

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Q. And in respect of Pacsai, your
best medical opinion at the time was that the
immediate cause of death was digoxin toxicity?

10

A. Yes.

11

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Q. And in respect of Miller, your
best medical opinion at the time was that the
immediate cause of death was digoxin toxicity?

13

14

A. Yes.

15

Q. Similarly in respect of Cook?

16

A. Yes.

17

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Q. Now, Doctor, if one had asked
you to give your best medical opinion on March 24th
even without the intervention of the police, would
that not have been your best medical opinion on that
date?

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A. Well, I think based on the
knowledge we had at the time and the circumstances I
was told about, this was one conclusion that the
digoxin played a significant role in the death of

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this patient but to me that would indicate that this problem should be investigated and try to find out what it means.

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Q. Now, Doctor, Mr. Scott in his cross-examination last week asked you about the Estrella reading, the gutter reading.

7

A. Yes.

8

Q. And you indicated that as far as you were concerned, having heard Dr. Taylor's evidence on how the levels were obtained and how the sample was collected, you felt that the sample was entirely worthless, those were your words?

13

A. Yes.

14

Q. Now, Doctor, is it fair to say that you are not a pharmacologist and your level of expertise does not extend to interpretation of digoxin readings?

17

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A. Well, I wouldn't consider myself an expert but we have learned some things during the two years which have passed and this is an opinion I gave after two years.

21

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Q. Well, Doctor, if a pharmacologist were to testify that the readings obtained in Estrella had some meaning, would you disagree with him?

23

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A. Well, I think in light of what



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I understand being two readings, one from a less contaminated or almost non-contaminated sample and this fluid sample, this is what I am basing my interpretation on as well. If you have a contaminated sample you cannot be absolutely sure what it refers to because you don't know the sources.

7

Q. But the contaminated sample ---

8

MR. SCOTT: Well, if I can just interrupt my friend. I want to be clear that a pharmacologist, as I understand it, has no expertise on whether the sample is contaminated or not, that would be a judgment for a pathologist. He simply will tell you what this reading may have been caused by or may mean, but the expert on whether the sample is contaminated is the person who takes the sample.

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THE COMMISSIONER: What about the effect of the contamination though, wouldn't a pharmacologist be more helpful than a pathologist?

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MR. SCOTT: Well, the question being put is a sample taken in these circumstances, is it going to be contaminated? That's the question. That's not a question for a pharmacologist. So, I don't want my friend to ---

THE COMMISSIONER: No, no, I agree

with you on that.



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MS. CECCHETTO: Q. Well, Doctor, the point I am getting at is - if one can agree that this sample was contaminated, aren't you then left with whether or not it would give you a false high or false low reading would be a matter for a pharmacologist and not a matter for you?

A. Well, a pharmacologist may try to explain it in a sense that you see what we are talking about is the serum levels which would be the level of the drug in the blood, and that is what we are interested in.

Now, once you are talking about level in some fluid from various sources you cannot transpose it to the blood level and you don't need a pharmacologist to tell you that. I think the significant level would be the one you measure in the serum, which is in the blood.

Q. Well, Dr. Mancer testified that last day the most that he could say was that the sample in his opinion was contaminated and he simply couldn't say whether it would be falsely high or falsely low. Would you disagree with that, Doctor?

A. I would agree with that.

Q. All right. Now, Doctor,

Mr. Scott also asked you in cross-examination about



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2 the sample taken from the leg of Janice Estrella.

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A. Yes.

4

Q. That is the sample that rendered
5 a greater than 4.7 reading?

6

A. Yes.

7 Q. And, Doctor, you indicated in
8 answer to a question by Mr. Scott in cross-examination
9 that you were satisfied that that greater than 4.7
10 reading, if there had been sufficient quantity for a
11 dilution, would not have rendered a greater than 10
reading?

12

A. Yes, that's what I said, yes.

13

Q. Doctor, is it impossible to know
14 what that sample would have rendered if there had
been a sufficient quantity?

15

A. I wouldn't think, you know,
16 you can't be absolutely sure what the reading is
17 without having the reading, but this is something
18 you would have to ask the biochemist who is doing
19 the test. But if you get a primary reading which is
20 in that neighbourhood, I would expect that even with
a dilution it would not go into hundreds.

21

Q. Well, Doctor, isn't it true
22 by my understanding of the evidence to date has been
23 that even if a sample was taken which would ultimately

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give you a 72 reading, your first reading would be greater than 4.7 and subsequent dilutions would give you higher readings. Is that not so?

5

A. Well, it may well be so, yes.

6

Q. Now, Doctor, today in cross-

7

examination Mr. Scott suggested to you that in coroner's cases the coroner would indicate to you what he is looking for in his coroner's warrant, or would assist you and give you some guidance perhaps?

10

A. Yes.

11

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Q. Isn't it fair to say, Doctor, that in a coroner's case the coroner lists his areas of concern in the warrant?

14

A. Yes.

15

Q. And he may have further discussions with you verbally?

16

A. Yes, that is correct.

17

Q. And isn't it fair to say further, Doctor, that after you performed the gross autopsy the coroner may modify his opinion on the matter in light of your findings?

21

A. Yes, he may.

22

Q. Now, in the Pacsai warrant there was a concern expressed about the high potassium levels, Doctor?

24

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2 A. Yes, there was.

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Q. So, to that extent the coroner
4 indicated that he was concerned about high potassium?

5

A. Well, he put a question mark in
6 terms of why is there high potassium in view of the
fact that no potassium was administered to the patient.
7 So, he put it as a sort of unexplained finding.

8

Q. Now, it is true that that
9 warrant does not list digoxin as an area of concern
but, Doctor, you indicated that in your review of
10 the chart you performed a digoxin test simply to be
thorough, that you were not concerned about the level
11 coming back sky-high, I believe your words were?
12

13

A. Would you rephrase the question,
14 please.

15

Q. You indicated that when you
16 performed the autopsy you took the digoxin test
because you wanted to be thorough. You didn't expect
17 that the samples would come back with markedly
18 elevated levels, is that correct?
19

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A. Yes.

21

Q. So, from a review of the chart
and in view of the fact that the last administration
22 of the drug was a 0.2 milligram reading there was
nothing to indicate that the child had received a
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2 toxic level of digoxin, was there?

3 A. Yes.

4 Q. Thank you. Now, Doctor, in
5 respect of the Miller case, you indicated that you
6 took the Miller sample because of your discussions
7 with Dr. Mancer. You were concerned that there were
8 two high levels of digoxin and you decided that it
9 would be prudent to take digoxin readings in the next
few cases that you were doing, is that correct?

10 A. Yes.

11 Q. Is it not true, Doctor, though
12 that in the Miller case there was an indication at -
13 the exhibit number is Exhibit 115 and pages 42 and 43
14 of the chart - there is an indication in the chart
15 that there is a 'hold digoxin' order. So, there was
16 some concern expressed about digoxin?

17 A. Yes, but this was in a
therapeutic management aspect rather than some other
18 aspect.

19 Q. In any event, Doctor, what
20 motivated you in Miller was simply because the previous
21 cases had registered high levels and you wanted to
examine the problem of digoxin?

22 A. Yes.

23 Q. Thank you. Now, Doctor, in

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2 respect of the Cook case, do you recall whether or
3 not Dr. Fowler indicated to you that he had advised
4 the coroner that there was going to be an autopsy
5 conducted on Cook and that there was going to be
6 digoxin samples taken on Cook?

7

A. Yes, that is my understanding,
yes.

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Q. Doctor, although the autopsy

was a limited autopsy, were you able to get all of
the blood and tissue samples from the heart and lung
in order to conduct the digoxin tests required?

12

A. Yes, I did.

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MS. CECCHETTO: Thank you, Doctor,
those are all my questions.

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THE COMMISSIONER: Thank you. Mr.
Young?

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CROSS-EXAMINATION BY MR. YOUNG:

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Q. Dr. Cutz, my name is David Young
and I am one of the lawyers representing the
Metropolitan Police at these proceedings.

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Doctor, you testified that you attended
a meeting on Monday, March 23rd in 1981 and at that
meeting there were representatives of the Toronto
Police Department.

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A. Yes.



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Q. There were also representatives
of the Coroner's Office, I believe?

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A. Yes.

5

Q. I believe Dr. Bennett was there?

6

A. Yes.

7

Q. And I think you told us that
there were other physicians from The Hospital for
Sick Children who were also at that meeting?

9

A. Yes, there were.

10

Q. Do you recall who they were?

11

A. I didn't write down the names of
all the people but I think from what I can remember
is Dr. Rowe, Dr. - I forget the name, the chief
psychiatrist, Quinton Rae or something like that ...

14

Q. I'm sorry, Doctor, I can't
hear you.

16

A. The chief psychiatrist was
there, and Dr. Fowler I believe, the Biochemistry
people I think, Dr. Hill.

19

Q. Do you recall Dr. MacLeod being
present at that meeting?

21

A. I'm not certain. He might have
been. The room was occupied. I mean, all the chairs
were occupied as I remember.

23

Q. There were a lot of doctors in
that room?

24

A. Yes, that is correct.

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Q. Doctor, at that meeting I understand from the police officers who were in attendance that the possibility of a digoxin overdose was discussed?

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A. Yes.

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Q. I think you have suggested a similar discussion taking place?

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A. Yes.

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Q. I understand also that a possibility of testing tissues within the Hospital for the content of digoxin was also something that was discussed at that meeting? Do you recall that?

13

A. That is right.

14

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Q. Do you recall discussion about the most likely method of administration of digoxin if indeed it was used as a murder weapon?

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A. Yes, I think that was mentioned but I can't recall as to who said it or when it was said.

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Q. Do you recall what was said?

A. I think, as I recall, it was said that an intravenous dose was the most likely possibility.

Q. And, Doctor, did anyone present at that meeting disagree or dissent with



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(Young)

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the tone of the conversation, with the discussions
that were taking place?

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A. Well, the meeting as far as
I could see was that that was really from our point
of view to see in what way we can help the police
investigation. It wasn't really a meeting to
decide what these readings or these findings mean.

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Q. I understand, Doctor, but would
it not have been helpful for someone indeed if they
believed this to express some dissent or dissatisfaction
with the theory that was being put forward?
Because my understanding was it was only a possible
explanation for these deaths?

14

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A. Well, that was my understanding
that this is what would take place.

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Q. That is right. Do you recall
any of the doctors at that meeting expressing any
dissent with respect to the discussion that we have
just outlined?

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A. Well, I think at that time
the information was very incomplete, was very scanty;
as I say the autopsy reports were not available.
These things were not completed. So there was only
a knowledge of the few cases in which the levels
were known, which I believe would be three patients



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or perhaps four.

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My understanding was that the purpose of the next meeting which would have been on Wednesday was actually to hash out, you know, the new information, some definite information with each of the departments.

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Q. Doctor, correct me if I am wrong: I understood that we were talking about a meeting that occurred on Monday, and there was a subsequent meeting on Tuesday?

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A. Yes. But there was, like on Monday I think we discussed only Cook, basically Cook, and then some discussion about these other cases. But, you konw, I haven't kept minutes of it.

15

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Q. No, I understand, Doctor. I just wondered if you could assist me with your best recollection.

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What was discussed about Cook at the Monday meeting?

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A. Well, at the Monday meeting I was particularly asked as to what the findings at post mortem were, and Dr. Bennett learning that there was only partial autopsy, he immediately instructed the police officers to track down the body and have a full autopsy done, a second autopsy I believe in



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Owen Sound. And he also instructed them to take
gastric and bowel contents for toxicology.

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Q. Doctor, I will ask once again.
Did you feel that - let me put it a little more
directly: did you feel that this was an appropriate,
appropriate actions for Dr. Bennett to suggest?

5

6

A. Yes, I would think so, yes.

7

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Q. Did you feel that the
suggestions during the Monday or Tuesday meeting
were appropriate in that it seemed logical that the
possibility of an intentional digoxin intoxication,
intentional dose of digoxin being administered to
these children should be examined?

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A. Yes, I should say so.

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Q. And you did not express any
disagreement with that --

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A. No.

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Q. -- with that possibility being
examined?

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A. Well, you know, looking at it

from the point of view of pathologists, you know,

we are quite remote from what is going on on the

ward and, you know, I can't really comment on whether

such a situation arise or what the situation is on

the ward.



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Q. You didn't comment on it?

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A. No, I did not.

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Q. And neither did any of the

5 clinicians who were present at that meeting?

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A. I can't recall it if there
7 were any comments on that.

8

Q. Doctor, I understood that on
9 the following day, on the Tuesday, Staff Sergeant
10 Sangster and Sergeant Barber came to your office
11 at approximately 11:20 a.m. and asked you to review
12 and complete a number of postmortem reports. Do
13 you recall that?

14

A. Yes, I recall that officers
15 came to see me but I am not certain of the time and
date.

16

Q. Do you recall what they
17 requested you to do?

18

A. Yes, I do.

19

Q. And it was simply to review
and complete a number of reports?

20

A. That is right.

21

Q. They didn't specifically ask
you to rate or comment or categorize the deaths in
22 a chart form?

23

A. Where my impression was that

24

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the actual request to review the cases came at the
Tuesday meeting, not from individual officers. I
am not sure as to who at the meeting brought this up.

5

6

7

Q. Doctor, that may be so, but
I thought you told us that you received a list for
the names at a later date. At a later time.

8

A. Yes.

9

Q. Perhaps in the same day?

10

11

A. Well, I can't recall as to who
received the list or who brought the list but it was
in the department.

12

13

Q. So you don't remember receiving
a list from Officers Sangster and Barber?

14

15

A. Not that I personally received
it, no, I can't recall it.

Q. What was your understanding as
to what you were supposed to do with this list?

17

18

19

A. Well, the understanding was
that we were to review the pathology findings in
these cases.

20

21

22

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Q. Since most of them were very
recent ones we suspected that many of them would not
be complete at that particular time, so that we would
have to complete them, adding the microscopic and
whatever other findings there were and furnish this



1

2

information to the police.

3

Q. And you did that?

4

A. Yes.

5

6

Q. And when did you complete the reports, Doctor?

7

8

A. Well, we worked on it I guess it was the Tuesday afternoon, the evening and until Wednesday morning.

9

Q. And, Doctor, you completed those reports, and Baby Pacsai, Baby Miller and Baby Cook, on their reports you indicated the immediate cause of death was digoxin toxicity?

10

A. That is correct, yes.

11

12

Q. And that was your professional opinion at the time as to the cause of death?

13

14

A. Well, this was based on the readings, levels, I was aware of, what was obtained in the postmortem samples on these infants, yes.

15

16

Q. And in your professional opinion that was likely the immediate cause of death?

17

18

A. That is right.

19

20

Q. And, Doctor, did police officers who you met with on Monday, Tuesday or at any time suggest to you or coerce you in any way to list digoxin intoxication as the cause of death?

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MR. SCOTT: Well now we are not
dealing with any time, are we?

3

MR. YOUNG: Well, all right.

4

MR. SCOTT: There will be a meeting
later on and I know we don't want to get into that.

5

MR. YOUNG: Q. Well, let's say,
Doctor, clearly to the point that you created the
documents and you told me that you finished the
documents by Wednesday morning I believe?

6

A. Yes.

7

Q. You finished creating them?

8

A. Yes.

9

Q. So up until that time, Doctor,
did anyone ever suggest to you or coerce you into
listing digoxin intoxication as a cause of death?

10

A. No, nobody coerced me into
it, no.

11

Q. Particularly the police
officers, they didn't suggest or coerce you in any
way to do that?

12

A. No.

13

Q. Doctor, I believe in answer
to one of Mr. Scott's questions last week you told
us that in fact even if the police had not been in
the Hospital, and I am paraphrasing - I would be

14

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2 happy to read the question to you if you like or if
3 your counsel likes - even if the police had not been
4 in the Hospital that in fact once you knew of the
5 dig. levels of Baby Pacsai, Miller and Cook, it is
6 quite likely that the same wording, the same import
7 would have been given to those readings and thus
8 the reports would have been prepared in a very
9 similar manner, and, I am suggesting this, Doctor,
likely with the same cause of death listed.

10 Would you agree with that? With or
11 without the police digoxin intoxication may have
12 been listed as the likely cause of death?

13 A. Yes.

14 Q. If I could take you back -
15 when I started asking you questions today we began
16 by discussing what occurred at the meetings on
17 Monday and on Tuesday, and I believe you told me
18 that there were a number of doctors there and that
19 you did not recall any dissent being expressed by
any of those doctors. Is that correct?

20 A. Yes.

21 Q. Doctor, would it be fair to
22 say that that lack of dissent or, if I might be so
23 bold as to call it tacit agreement (perhaps it was
an overt agreement) did that influence you in any way

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in deciding that digoxin intoxication may well be
the likely cause of death of Baby Estrella, Baby
Cook, Baby Pacsai and Baby Miller?

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A. Well, I think the meetings
itself to me was one of the reasons I could
see to hold such a meeting was to gather information
from the various people involved with these patients.
And I guess it was just a discussion to get this
information.

10

Q. Well, Doctor --

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A. But the fact there was a

police investigation led by the homicide squad
and the context of mentioning this incident, you
know, it was quite obvious that they are looking at
criminal activity. They are not making a scientific -

Q. Agreed.

A. -- examination.

Q. And more specifically they

were looking at a criminal activity that was
described as an intentional administration of digoxin,
and that would likely have accounted for the death
of these babies?

A. That is correct.

Q. Doctor, I am going back to the
other point that I began with, but if indeed any of



Cutz, cr.ex.
(Young)

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these doctors at the meeting, and I think present
at the meeting at one time or another was Dr. MacLeod
who was a pharmacologist, and a biochemist you have
told us was present there and a number of very
senior doctors in the Hospital.

7

A. Yes.

8
9
10

Q. If they had expressed some
dissatisfaction with this theory would you have been
a little less certain as to the accuracy of what was
being suggested?

11
12

A. Well, I had some discussions
subsequent with Dr. MacLeod.

13

Q. Yes.

14
15
16

A. Regarding that, and there was
no consensus as far as how we should interpret these
results. In other words he wasn't certain what these
results mean.

17

Q. He certainly left the
possibility of a digoxin overdose open, did he not?

18
19

A. Yes.

20
21
22
23
24

Q. And if he hadn't, if he had
told you that there is a million possible explana-
tions and it is rather unlikely that a digoxin over-
dose was the cause of death, you would have considered
that and likely altered your findings?

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A. Well, if there was some study showing this to be so then you would have to question the whole thing, but we were not aware of any such studies and what was known about it. This was the only conclusion we could make.

7

8

Q. Thank you, Doctor. I have a few more questions.

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When Mr. Scott was questioning you, you also suggested that the result - let me list it this way: the cause of death listed on the final autopsy report of Baby Estrella was somewhat different than the cause of death listed on the preliminary report of Baby Estrella, and I think it was put to you that the presence of the police in the Hospital likely contributed to that change.

21

22

23

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MR. SCOTT: No, I think the question related to the contrast between the autopsy report of Estrella and the chart that Dr. Mancer and this Doctor prepared which shows digoxin toxicity as the cause, and the doctor explained how he selected those causes.

21

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MR. YOUNG: I agree. I apologize, Mr. Commissioner.

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Q. Doctor, would it not be fair to say, though, that that change might have been



Cutz, cr.ex.
(Young)

G13

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2 explained not by the fact that the police were in
3 the Hospital but by the fact that there were actually,
4 from the time that the Estrella readings were first
5 found out, there were actually three additional
6 unprecedently high digoxin levels that were
7 returned?

8 A. Yes.

9 Q. That of Baby Cook, Baby Miller
10 and Baby Pacsai. Did that not really account for
11 any change that might have taken place with respect
12 to how Estrella's cause of death was analyzed?

13 A. Well, the list - really I
14 would just like to stress again we didn't look at it
15 as some kind of a document cast in stone.

16 Q. I understand, Doctor.

17 A. This is a summary of the
18 reports to assist in discussing these individual
19 cases. It was written in terms so the layperson
20 can understand it, and it was written as far as,
you know, what the individual causes are with the
highest degree of suspicion we could come up with.

21 Q. That is right, and you came up
22 with an digoxin overdose as being a possible cause
23 of death?

24 A. That is right, if one is

25



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considering this as this being the matter under investigation that this actually had occurred, this is what our impression was.

5

6

7

Q. Doctor, was it not three unprecedently high digoxin levels that occurred after Estrella that raised your suspicion?

8

9

10

11

A. Well, I had no suspicion because I didn't have all the information available. All I had was autopsy findings and the readings, but I don't know what was going on in the wards or otherwise.

12

13

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Q. And in fact you didn't hear anything at the Monday or Tuesday meeting which satisfied you as to what was going on at the wards that could account for these high digoxin levels, did you?

18

19

A. Well, I think, you know, what was discussed was a criminal activity.

20

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Q. Well, let's not go through that again.

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Doctor, in fact these unprecedented levels with all four children were really the reason for the police investigation, were they not?

A. Yes, I believe so.

Q. A few more questions, Doctor.



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How long after you complete an autopsy
do you usually prepare a preliminary postmortem
report?

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A. Well, if it is the Hospital
case that is not under a coroner's warrant then the
preliminary is usually prepared within 24 to 48
hours after the completion of the autopsy.

9

10

Q. And if it is a coroner's case
is there a similar document, a comparable document
that is prepared within that time period?

11

12

13

14

15

A. No, there is not. If these
documents came up those are our personal notes, and
the only report as far as coroner's case is
concerned is the final report on the coroner's form.
There should be no other report.

16

17

18

19

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Q. Doctor, earlier today we got
a chance to look at what is now Exhibit 106C I
believe which is also included in the Pacsai chart
at page 94, and I understand that it is not a
preliminary autopsy report yet it is on a form which
is entitled such.

21

Page 94, Doctor.

22

23

Correct me if I am wrong, but I believe
that is the same document that was produced earlier
today?

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A. Yes.

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Q. Doctor, when was this document
created?

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A. Well, this document would have
been or must have been created after the 18th. This
is when I learned of the level.

8

Q. And in fact you list the level?

9

A. Yes.

10

Q. The very last sentence, in the
middle of the first page you said:

11

12

13

"The immediate cause of death is
digitalis toxicity (postmortem blood
level detected was...)"

14

At 26 nanograms. Actually it is ug. What is that,
Doctor?

15

16

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19

20

A. It should have been --

Q. Nanograms?

A. Microhm.

Q. It should have been 26 --

A. Well a microhm is instead of
the 'u' a Greek 'm'.

21

22

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Q. Okay, Doctor. This report was
created after the 18th?

A. Yes.

Q. Can you be of any more assistance



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to me?

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A. Well, under normal circumstances this would not be prepared, as I mentioned, because this was a coroner's case, and this is just for me to keep notes so I remember later on what the situation or what the findings were. So that this report was prepared to assist the investigation at that time, you know, which lists what sort of findings we had.

Q. Doctor --

A. What extent the investigation is complete.

Q. Doctor, do you recall when you gave this report to the Metropolitan Toronto Police?

A. Well, I can't recall the exact hour or date, but it was during that week. It could have been either Monday or Tuesday or Wednesday.

Q. Well, you have told us I believe you didn't meet with the police on Wednesday so it was likely Monday or Tuesday.

A. Yes.

Q. Do you recall - can you picture yourself?--

THE COMMISSIONER: Well, I think it



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is more apt - it is likely to be later than
Tuesday. I may be wrong.

4

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MR. YOUNG: Well, I don't think so,
Mr. Commissioner. My point is that it was likely
prior to Monday.

7

8

Q. But, Doctor, you can help me
with that.

9

10

11

12

MR. SCOTT: I think he told me that
he gave it to the police the same time that he gave
them the blank coroner's report, and if my friend
wants to pursue it maybe he can find out when that
was prepared.

13

14

15

MR. YOUNG: Q. Well, Doctor, if I
was to suggest to you it was Monday morning when
you gave this document to the police, would that
seem appropriate?

16

17

A. Well, it is quite possible,
yes.

18

19

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DM/cr 2

Q. And do you recall having this
document typed on Monday morning?

A. Well it would be possible,
because I would have known about - the first time I
learned about it was on the 18th.

Q. Yes, I understand.

A. Yes.

Q. But how does that make it
possible that it was typed on Monday morning?

A. Well I don't think it would
have been typed Monday morning because the meeting
took place before 10 o'clock, or 10 o'clock, so I
don't think I would have had time to have it typed.

Q. Doctor, my point is this; at
the top of this form you list "digitalis toxicity
heart failure"?

A. Yes.

Q. At the bottom as I have
already read you state: "The immediate cause of
death is digitalis toxicity".

A. Yes.

Q. You told us earlier that you
were not aware there was a police investigation going
on within the Hospital until Monday morning, March
23rd.

24

25



(Young)

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2 A. No, Sunday.

3

Q. Well, okay, I thought it was
4 Monday, Doctor.

5

A. No, Sunday when we did the
6 autopsy on infant Cook, Dr. Fowler came to the
7 autopsy room and told me that high levels of digoxin
8 were found in the sample which they took, either
9 pre-mortem or immediately post-mortem, and it is in
10 a patient who did not, who had not been prescribed
digoxin.

11

Q. Yes.

12

A. And then he told me the police
had been called in to investigate.

13

Q. . . That the police had been
14 called in to investigate?

15

A. That's right.

16

Q. Now doctor, can you tell me,
17 you prepared this report, this report entitled
18 "Preliminary Autopsy Report" prior to learning,
learning that information on Sunday morning?

19

A. No. I most likely - this was
20 prepared in those three days of the week, that is
21 Monday, Tuesday or Wednesday, which I am not, you
22 know, I am not certain.

23

Q. You are not certain?

24

25



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2 A. No.

3

Q. Doctor, a few more questions.

4

You have conducted, I understand at the Hospital
tests for digoxin have been conducted on a regular
basis since March 25th, 1981, is that correct?

5

A. That is correct.

6

Q. When do you conduct those
tests? What is the criteria for conducting those
tests. Do you do it on every child you autopsy?

7

A. That is correct, yes.

8

Q. Any child from any ward that
you autopsy?

9

A. That is correct.

10

Q. And if the child had not
been in the Hospital for Sick Children you still
conduct it?

11

A. We still do it, yes.

12

Q. And I take it, Doctor, that
you receive back the results of those blood tests
that were assayed for digoxin?

13

A. Yes, we do.

14

Q. Doctor, have you since March
25th, 1981, ever received back digoxin levels
comparable to those found in Baby Estrella; I will
remind you, Doctor, the postmortem level there was
one of greater than 4.7 and another of 72. Have you

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ever received back a comparable result to that?

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A. No, I think if I just may mention here, the study which you are referring to was initiated under the directive of Dr. Bennett.

6

Q. Yes.

7

8

9

A. And has been coordinated with the Coroner's office, the Centre for Forensic Sciences and the Department of Pathology. It is actually Dr. Phillips who is in charge of the results from the cases we examined, so he would be the first who would receive them, plus they would catalogue them and analyse them. So even though I received these readings later on it is just from a small portion of the total cases.

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Q. I understand, but I am

interested in which you have received, Doctor. Have you ever received readings similar to the 72 seen in Estrella; the 26 in Pacsai; the 78 in Miller; or the greater than 100 post mortem, and 72 I believe ante mortem in Cook?

A. Not in the cases I have

examined, no, I have not.

MR. YOUNG: Thank you, Doctor.

THE COMMISSIONER: Thank you. Yes,

Miss Symes.



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2

CROSS-EXAMINATION BY MS. SYMES:

3

Q. Dr. Cutz, did you have
anything to do with the autopsy on Gary Murphy
in which there was an inquest?

5

A. No, I did not.

6

7

8

9

10

Q. Dr. Cutz, my name is Beth
Symes and I represent the Registered Nurses Association
of Ontario and a number of nurses who were involved
in the cases. I have just three brief questions of
you.

11

12

13

When you took the Cook sample of heart
tissue during the autopsy and took it to the Centre
for Forensic Sciences, did you place in a preservative?

14

A. No, I did not.

15

16

Q. How did you transport it there,
what did you do with it once you had cut it from the
heart?

17

18

A. It was put in a glass bottle,
or a jar, a glass jar which is then closed and
transported as is.

19

20

Q. And you personally transported
it?

21

A. That is correct.

22

23

Q. And did you give it to someone
at the Centre?

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A. Well it was, you know, I was met by a Constable who was on duty then and he indicated to me that the sample should be locked in a special freezer or fridge, so that is where it was placed.

Q. So to the best of your knowledge then it was frozen without preservatives?

A. No it was fresh tissue without preservatives which was kept in a fridge. Now, I don't know whether it was frozen or just 4 degrees.

Q. Oh, I see. Now the meeting that you went to on Monday, you said there were a lot of people present?

A. Yes.

Q. This is the meeting; and you said it essentially focussed mainly on the death of Baby Cook?

A. Yes.

Q. At that time was there any discussion as to whether or not there could have been a medication error?

A. I don't recall that there was really discussion regarding how these readings, or how these levels came about. I think there was a discussion, the spirit of the discussion was



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criminal activity took place in the Hospital and we were discussing the ways to, you know, how to continue with the investigation, or how to contribute to the investigation.

5

Q. But Dr. Cutz, that was to contribute towards the investigation of an intentional overdose of digoxin?

8

A. That's right.

6

Q. Was anyone there assigned to investigate as to whether or not there had been an innocent explanation?

11

A. Not that I am aware of.

12

Q. And finally, perhaps you can help me about the Tuesday meeting, I am a bit confused about the meetings the next week. When was the Tuesday meeting held?

16

A. It was at the same time, I
think 10 o'clock in the morning.

Q. And at this particular time you were then asked if you would sign out the autopsy reports that remained pending?

20

A. That is correct.

21

Q. And that is the ones that are
the list, handwritten list?

23

A. That is correct, yes.

24



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2 Q. And I believe that you told

3

Mr. Young that you worked Tuesday afternoon, Tuesday
evening, and did you work throughout the night to
get the results finished by Wednesday morning?

4

5 A. Well we worked quite late at

6 night, yes.

7

8 Q. Can you give me any idea how

9

late you worked?

10

11 A. Well, we had, there was two

of us, myself and Dr. Mancer.

12

Q. Yes.

13

A. Because we didn't want other

14

people to get involved in it. We understood it was
something kept under secrecy and so we had to finish
nine or ten reports.

15

Q. Yes.

16

A. So that, whether we worked

17

until midnight, I can't remember, but certainly it
took a lot of effort on our part and the technicians
to prepare the slides, et cetera, yes.

18

Q. So you would agree with me

then that you were doing these reports and you were

under a fair degree of pressure?

22

A. Time pressure, yes.

23

Q. Certainly there was time

24

25



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2 pressure, and there was also the fact of the
3 consequences that might come from your decisions?

4 A. That is correct.

5 Q. On your opinions?

6 A. Yes.

7 Q. And normally you have the
8 assistance I gather of the resident pathologist there
9 to provide information or whatever with respect to
these events as well, don't you?

10 A. Yes.

11 Q. You didn't have Dr. Taylor
12 there?

13 A. No, we did have Dr. Taylor,
14 because he actually was involved in a large number of
15 these cases. So the ones that I was involved together
with him we reviewed together.

16 Q. So the ones that you and Dr.
17 Taylor had been involved in you two reviewed and
18 similarly Dr. Mancer and Dr. Taylor?

19 A. Yes, I believe so.

20 Q. And if there were any other
21 resident pathologist, was he or she present?

22 A. Not that I - I can't recall
if any other residents were involved with the cases.

23 Q. And I gather then during this

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time from Tuesday afternoon, Tuesday evening through
Tuesday night to Wednesday you would have had to
review the charge and the preliminary autopsy report,
if there was one?

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A. The chart we didn't really
have time to review the chart, but we reviewed the
gross findings and the microscopic findings and
whatever other lab results were available at the
time.

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Q. Just so I can understand,

because I gather you have said the technician actually
had to cut and prepare the slides?

A. That is right.

Q. And you would then have to
examine those?

A. That is correct.

Q. And that involves a number of
slides for each of these autopsies?

A. That is correct, yes.

Q. So that the amount of physical
work that was required of you during that afternoon,
evening and night, was quite considerable?

A. That is correct, yes.

Q. I gather you don't normally
prepare final autopsy reports with that kind of

24

25



1

2 time table?

3

A. No, we don't.

4

Q. How long do you normally take
for the part whereby one takes a preliminary autopsy
report without microscopic findings to final autopsy
reports if one has to look at microscopic results?

5

6

A. I would say an average of
about two months.

7

Q. And average of two months.

8

How much time, how many hours involved?

9

10

A. Well it depends on the complexity of the case, but the actual waiting period is to get all the slides and the materials and the results back from either our labs or different labs, and then the actual review can take from one hour to several hours.

11

Q. And give me the most.

12

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A. Well I would say maybe three to four hours would be a maximum I would spend at one sitting.

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Q. And in cardiology patients

what is an average?

A. Again it depends on the

complexity of the case and it can vary the same - we might ask, we might ask for consultation with



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2 the cardiologist or some other people.

3 Q. And you certainly didn't have
4 the time with these constraints on you for these
5 particular cases?

6 A. No, you need to do a literature
7 review or things like that.

8 Q. And you didn't do any literature
9 review?

10 A. Well we could not do that,
11 no.

12 Q. Obviously not. Then on this
13 particular afternoon, evening and night then, you
14 did for each of these cases what might take you up
15 to five hours, microscopic review on a single one?

16 A. Yes.

17 Q. And you also dictated the
18 final report?

19 A. Yes.

20 MS. SYMES: Those are my questions,
21 thank you.

22 THE COMMISSIONER: Thank you. I
23 think we will take a lunch break now until 2:30.
24 Do you want to give some indication?

25 MR. KNAZAN: Less than 15 minutes,
26 Mr. Commissioner.



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2 THE COMMISSIONER: Mr. Olah?

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MR. OLAH: Very short.

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THE COMMISSIONER: Mr. Labow?

5

MR. LABOW: 20 minutes, Mr. Commissioner.

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THE COMMISSIONER: Mr. Shinehoft?

7

MR. SHINEHOFT: Maybe 15 minutes or

so, Mr. Commissioner.

8

THE COMMISSIONER: I think that occupies
9 the afternoon.

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11

12 ---Luncheon recess.

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RCHSC
Oct 11
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ANGUS, STONEHOUSE & CO. LTD.
TORONTO, ONTARIO

Cutz, cr.ex.
(Knazan)

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BmB.jc
AA 1

2 ---- Upon resuming:

3 THE COMMISSIONER: Yes, Mr. Knazan.

4 CROSS-EXAMINATION BY MR. KNAZAN:

5 Q. Dr. Cutz, I represent Maryanne
6 Christie, a Registered Nursing Assistant. I would
7 like you to direct your mind please to Phillip Turner.
8 You testified to Miss Cronk that at the time you
9 signed the final autopsy report - this was in July
10 of 1980 - you had no concern about digoxin as a
cause of death?

11 A. That is correct, yes.

12 Q. Is that still your opinion now?

13 A. Yes, it is.

14 Q. That was an autopsy that you
supervised, is that correct?

15 A. That is correct, yes.

16 Q. That you would have had a chance
to leaf through the medical chart before beginning?

17 A. Yes.

18 Q. And you would have been aware
of the mode of death?

19 A. If I may just get my copy to
refresh my memory.

20 Q. I'm sorry, do you need the
exhibit?

21
22
23
24
25



AA.2

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A. Yes, I have it.

2

Q. You would have been aware of
the mode of death?

3

A. Yes, I think so.

4

Q. And of course you are now,
having had an opportunity to re-read it to testify for
this, you are now aware of the mode of death, arrest?

5

A. Yes.

6

Q. And everything that accompanied
it?

7

A. Yes.

8

Q. And it is still your opinion
that there is no concern about digoxin in this case?

9

A. No, I wouldn't think so, no.

10

Q. All right. Now, if a cardiologist,
however eminent, were to give his opinion, based upon
a reading of the chart, that that death was consistent
with special concern regarding possible digoxin
intoxication, then that would be an opinion that you
would disagree with, is that correct?

11

A. Well, I think it would be very
difficult to reconcile, in view of the fact of the
type of disease this child had, namely, a hypoplastic
left heart, which is invariably fatal, there is
nobody that has survived with this. So that you could

12

13



AA.3

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2 postulate numbers of other mechanisms in addition to
3 digoxin.

4 Q. Now, you indicated to Mr. Scott
5 three kinds of findings on which you may base a final
6 opinion as to cause of death: anatomical, biochemical
7 and pathophysiological. Am I correct that as far as
8 the second two, biochemical and pathophysiological go,
you would be dependent on the findings of others?

9

A. That is correct, yes.

10

Q. Whereas, for the anatomical
cause of death you could come to conclusions on your
own in the autopsy room on the basis of your autopsy?

11

A. That is correct.

12

Q. Now, with reference to digoxin,
at the time of these events, say, early 1981, were
you aware if digoxin left any anatomical findings if
it were the cause of death?

13

A. Well, I was, you know, we are
aware of what drugs produce what kind of tissue
reaction. There are certain drugs which produce
specific types of marks if you like in the tissues
by which you can recognize or suspect it, but digoxin
is one of the drugs which does not.

14

Q. Now, you now know that it does
not.

15

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AA. 4

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A. Well, we knew it then too. You would not have expected to see any tissue damage or changes which you could ascribe as being due to digoxin.

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Q. I understood from your testimony that there was very little literature about any of this at the time, the effects of digoxin in toxic doses.

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A. Well, the literature which is very scanty refers to what happens to digoxin after death in terms of how you should interpret the levels you get in postmortem samples and what it means, how to relate it with the pre mortem or in the living patients.

Q.

Well, was there any or abundant literature on the anatomical findings after death by digoxin overdose?

A.

No, there wasn't. But from the type of drug one is talking about, you know, you can presume certain things, like, what would be called predictable tissue reaction and so forth, unpredictable.

Q.

Could the actual existence of the drug in the body, would that be an anatomical finding too?

A.

No, that would not be.



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Q. So, just back to your last

answer. That knowledge that digoxin would leave no anatomical findings would be knowledge you had as a pathologist?

A. Yes, I think that would be correct.

Q. But it wouldn't be readily available in the literature to, say, another doctor or someone perusing through the Hospital library?

A. Well, we looked up the literature available. I didn't find any reference which would say that there are changes.

THE COMMISSIONER: Did you find any literature that said that there were not?

THE WITNESS: Well, I think from the type of drug it is you would not expect for it to show changes in the tissues.

THE COMMISSIONER: You would not. I wouldn't have the faintest idea. Tell me, would one, would a doctor or anyone familiar with the matter, would they know?

THE WITNESS: Well, you know, somebody who would be specifically interested in digoxin toxicity, who has done extensive studies, they might perhaps shed some light if there are changes or not



AA.6

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2 but I would be almost certain that there are no
3 changes which a pathologist can see with the naked
4 eye examination or the routine microscopic
examination.

5

6 THE COMMISSIONER: Well, why were you
7 aware of it if there were no changes? I mean, you
8 never went looking for digoxin effects. Is this part
of your education?

9

THE WITNESS: Yes, it is.

10

11 THE COMMISSIONER: Where do you take
that, or where did you take that?

12

13 THE WITNESS: Well, part of the study
14 of pathology is the study of diseases produced by
various agents and one of these agents would be drugs
15 and would be both therapeutic types of drugs which
are given to patients and then there would be other
16 toxic substances from the environment which produce
17 changes in tissues.

18

19 THE COMMISSIONER: What other drugs
do you know of that do not have any - leave any marks
on the tissues or otherwise be detectable?

20

21 THE WITNESS: Well, I think a lot of
22 the drugs which would act, say, on the central nervous
system or nervous tissue and which would be volatile,
23 which you might not even detect the drug post mortem,

24

25



AA.7

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2 there would be a number of anaesthetics, for instance,
3 which may not - you know, we may not be able to
4 demonstrate any changes. Then, with drugs it depends
5 on many other aspects, other conditions, the dosage
6 of the drug, the patient's reaction to it.

6

7 THE COMMISSIONER: Well, I take it
8 if there is an overdose of a drug like heroin, would
9 that be detectable in the system?

9

10 THE WITNESS: Well, you would detect
11 the drug but you would not necessarily - for instance,
12 if you would examine somebody who died from this over-
13 dose, without having the prior knowledge that that
14 is what happened, plus having the analysis done, you
15 would not be able to say ---

(2)

14

15 THE COMMISSIONER: I am assuming that
16 you don't have them specially checked by a biochemist.
17 Would you as a pathologist doing your autopsy would
18 you know if a person who were dead and you knew
19 nothing about the heroin if he had died of that?

20

21 THE WITNESS: No, unless you do the
22 test you would never know.

23

24 THE COMMISSIONER: Does that apply to
25 all drugs?

22

23 THE WITNESS: More or less, yes.

23

24 MR. KNAZAN: I was just turning to
25 Pacsai. Are you finished, sir?

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AA.8

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THE COMMISSIONER: Well, I just wondered. There are no traces of the drug itself I suppose left in the system, it is all absorbed by the system, isn't it?

THE WITNESS: Well, if the drug does damage then you can usually see the evidence of the damage and there are certain organs, for instance, like liver, which would be often injured or would be susceptible to drug injury, then you would see the changes. The heart also is susceptible to damage by certain drugs. There is an anti-cancer drug which is used quite frequently, adriamycin, it is a type of antibiotic and is highly toxic to the myocardium, to the muscle, and then you will see changes in a patient who is receiving this drug and who dies of heart disease due to the drug then you would see extensive changes in the myocardium which you can then ascribe as being due to the drug. But there are a number of other drugs where you don't see a thing.

THE COMMISSIONER: People who take overdoses of drugs as suicidal, something of that nature, how do they know, how do they know other than the fact that they are in a coma when they first arrive at the hospital if there is nothing afterwards to show on the pathological examination?



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THE WITNESS: Well, I think then again if you have no evidence that such a person or you have no knowledge that such a person has taken drugs or received drugs, there is no way the pathologist can say this patient died from a drug overdose unless he has made the tests for the drug. He may suspect it. He might say, well, it might be that this patient died from a drug overdose.

THE COMMISSIONER: Would you normally do that if someone came into the hospital under circumstances that looked suspiciously like a drug overdose, would you - and if an autopsy were authorized - would you test for that drug?

THE WITNESS: Well, I would think that in such a case the case would most likely be a coroner's case.

THE COMMISSIONER: Well, let's say it is a coroner's case. I don't really care one way or another.

THE WITNESS: Yes.

THE COMMISSIONER: But let us say it is a coroner's case and you get a warrant and he wants you to find out the cause of death, what would you do?

THE WITNESS: Well, I think in such a case then toxicology may be, you know, would be a part of the investigation.



AA.10

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THE COMMISSIONER: How would you know
which drugs to test for?

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THE WITNESS: Well, I think you would
ask for common drugs first, to screen for common
drugs, and then if that screen is negative then to go
for some other less common ones, depending on what the
further investigation reveals, which direction one
should go. But it may be completely up in the air,
you might come negative with everything.

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THE COMMISSIONER: Would you ever
consider digoxin as being one of the drugs which
people might commit suicide, with the help of?

THE WITNESS: I think digoxin usually
is an accidental overdose type of drug but I don't
know if people actually take it as a suicidal drug.
It is usually other drugs.

THE COMMISSIONER: Yes, all right.

Sorry, Mr. Knazan.

MR. KNAZAN: Q. Just to ask a couple
of questions on Pacsai. You stated that one of the
reasons that you directed your mind towards digoxin
was that you saw two notes of Dr. Costigan's query
digoxin toxicity. Do you remember another note by
Dr. Costigan with another differential diagnosis of
sick sinus syndrome?



AA.11

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A. Yes, I do.

2

Q. Is that the same as the
conduction problem you were talking about?

5

A. That is correct, yes.

6

Q. So, you did direct your mind
towards that note also?

7

A. Yes.

8

Q. That that was never concluded
because of the difficulty of doing the tests?

10

A. Correct, yes.

11

Q. Just one other thing. You
mentioned in your evidence in chief that you took
samples on a medical legal case that you were doing.

13

A. Yes.

14

Q. The same day as Miller. Is that
the same case as the child who died at home that you
testified about this morning?

17

A. Yes.

18

MR. KNAZAN: Thank you.

19

THE COMMISSIONER: Thank you, Mr. Knazan.

20

Mr. Olah?

21

CROSS-EXAMINATION BY MR. OLAH:

22

Q. Doctor, I act for the other
registered nursing assistant on the Trayner team. A
couple of things that I was intrigued by following

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your evidence. I understand that subsequent to rendering an opinion as to the cause of death in Pacsai, Miller and Cook, you took some interest in the development and unfolding of digoxin literature that became available?

A. Well, that would be during and after.

Q. I understand that.

A. Yes.

Q. In the two years, two and a half years since rendering those opinions, have you followed the literature that has unfolded as to digoxin and its activities of human tissue?

A. Well, I have followed literature to the extent of aspects which interested me but I am aware that a much more detailed study is being done with experts in the field. So, I leave it up to them rather than for me to do extensive research.

Q. I understand that. But insofar as it relates to your specialty, pathology, I take it you have followed the developments in the literature?

A. That is correct, yes.

Q. Really what I just wanted to get at was this. Given the new knowledge that has been established with respect to digoxin, does that in any



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way alter or change your opinions as to the cause of
death in the Pacsai case?

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A. Well, I think there again it's
a question of whether we can explain this high level
or not. If we can explain it on some scientific basis
or some other evidence which would indicate that you
can get such a high level under normal circumstances,
then I think that that would have to be modified.

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Q. All right. Well, bearing in
mind that we've got an ante mortem reading of greater
than 10 and then we've got the post mortem reading
that we did obtain, is it your opinion today still
that the cause of death in the Pacsai case was
digoxin intoxication or something else?

A. Well, I think I would still
have to consider it as a cause of death, yes.

Q. Well, would you consider it as
a cause of death or the cause of death?

A. Well, I think if the level sticks
as being a level which you could not get any other way
just say by overdose of the drug, then that would
have to be still considered as the primary cause of
death.

Q. So, given that qualification
your opinion today still is that Pacsai is as a result



AA.14

1

2 of digoxin, the death of Pacsai is caused by digoxin
3 toxicity?

4

A. Well, I would have to say that,
5 yes.

6

Q. And similarly I take it that is
7 your opinion with that qualification with respect to
Miller and Cook?

8

A. That's correct.

9

Q. Now, on March 20th when you by
chance discussed the readings that you found or heard
about in the Pacsai case with Dr. Mancer, at that time
I understand he told you about the finding in Estrella?

12

A. That is correct, yes.

13

Q. And he said that he was dismissing
the Estrella readings because he felt that there was
a laboratory error?

16

A. That is correct, yes.

17

Q. And that's what he told you?

18

A. Yes.

19

Q. Did he tell you anything else,
any other grounds for dismissing the Estrella sample?

20

A. I'm not quite sure whether he
mentioned the contamination but my overall impression
was that at the time, that is, before I told him about
the Pacsai result, the whole result was considered to

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AA.15

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2 be meaningless or, in other words, they thought there
3 was some gross error and they couldn't interpret it.

4 Q. All right, but the gross error,
5 as I understand your evidence, was on the basis of a
6 laboratory error. That was what was suspected?

7 A. That's what he thought, yes.

8 Q. That's what he told you?

9 A. Yes.

10 Q. And you can't recall whether he
11 told you anything about contamination?

12 A. Well, he might have told me
13 that but I didn't think that was the main thing at
14 the time.

15 Q. All right. Of course, when you
16 heard about the Pacsai level you checked with Dr. Ellis
17 to determine whether there had been a laboratory
18 error?

19 A. Well, we discussed it to see
20 what other, you know, under what conditions you could
21 get this level, plus, we were not really sure what
22 happens with digoxin post mortem, whether it goes up
23 or goes down or whatever.

24 Q. But the point I am making is,
25 you were concerned about a laboratory error as soon as
 you heard about it and you verified that it wasn't?



AA.16

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A. Yes.

2

Q. As far as you could at that time?

3

A. Yes.

4

Q. That was shortly after receiving
or hearing about the level?

5

A. That's correct.

6

MR. OLAH: Thank you, Doctor, those
are all the questions I have.

7

THE COMMISSIONER: Thank you, Mr. Olah.

8

Mr. Labow?

9

CROSS-EXAMINATION BY MR. LABOW:

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Q. Doctor, my name is Labow and I
represent the parents of a number of the children who
died at the Hospital.

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BB/EMT/ak

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Just to make it clear you discussed
with Mr. Scott this morning three kinds of pathological
findings.

5

A. Three types of causes of death.

6

Q. Right. The second kind was
biochemical.

7

A. Yes.

8

Q. Now my understanding from
what you told us that digoxin intoxication as a
cause of death would have to be a biochemical cause?

11

A. That is correct, yes.

12

Q. You couldn't determine it at
a regular autopsy?

14

A. No.

15

MR. LABOW: I would like to look at
two exhibits, Mr. Registrar. Exhibit 44 is the
Turner Hospital record and Exhibit 113 is the Inwood
Hospital record.

18

Q. Now you supervised the

19

autopsy of Phillip Turner?

20

A. That is correct.

21

Q. And your evidence is that you
were briefed by the resident who was Dr. Srigley?

23

A. Yes.

24

Q. Leafed through the record?

25



BB2

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A. Yes.

2

Q. And were present at times
during the autopsy?

3

A. That is correct, yes.

4

Q. And then you also went on to
point out that there were obvious findings regarding
a very complex type of congenital heart disease?

5

A. That is correct.

6

Q. And you had no concern about
digoxin intoxication being a cause of death?

7

A. No, I did not.

8

Q. Now when you leafed through
the record do I take it that you did not look at the
record in depth?

9

A. Yes.

10

Q. When you leafed through the
hospital record was that prior to the autopsy, the
gross autopsy being undertaken?

11

A. Yes, it would be.

12

Q. And do I take it correctly
that you didn't leaf through it in depth?

13

A. Well, it is a long time ago so
I can't recall exactly to what depth I would have
leafed through it, but, you know, I would definitely
just go through the chart checking the things which

14

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I am told by the resident.

3

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Q. Do you recall what the resident told you?

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A. Again I can't remember everything, but he probably told me what the problems were in terms of the expected diagnosis for a complex congenital heart disease, and I would have thought it would have been a straightforward case with the type of disease he had.

10

11

12

Q. Well, Doctor, this child was in the Intensive Care Unit for a relatively prolonged period.

13

A. Yes.

14

Q. And was transferred to the wards on the 30th of July.

15

A. Yes.

16

Q. And died just over a day later?

17

A. Yes.

18

19

Q. Now my understanding from Dr. Rowe's evidence, and this is found at page 1820, is that if he was transferred from the ICU to the ward it would suggest that he was not regarded as being in imminent risk of death.

20

21

22

Dr. Rowe goes on to say he would not be transferred if they thought that the child was

23

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BB4

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2 going to die suddenly. Does that make sense?

3

4 A. Well, the thing is with the
5 type of heart disease this patient had, and as I
6 mentioned before hypoplastic left heart is 100%
7 fatal. It is only a question of time. And I believe
8 this patient had some attempted surgery to correct,
9 you know, to correct some, which is an experimental
10 type of surgery with about almost 100% mortality.
11 So that I think it would be too optimistic for
12 Dr. Rowe to say that, you know, the patient's
13 prognosis was good which in fact, you know, it is not.

10

11

12 Q. Well, he didn't say it was
13 good, but he said if the child was transferred from
14 Intensive care to the ward --

15

A. Yes.

16

Q. -- that would suggest that the
child wasn't in imminent danger.

17

18

A. Well, he might have been
stabilized at that particular moment, yes.

19

Q. But he died a day later?

20

A. Yes.

21

Q. Do you recall if it was brought
to your attention that he died quickly after he
was transferred to Ward 4A?

22

23

A. No, I don't think so.

24

25



BB5

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Q. Now you have just explained to my friend that you don't think that this is consistent with a special concern as one of the other cardiologists has mentioned about this child regarding digoxin intoxication.

7

8

9

You wouldn't think that was the cause of death?

10

11

12

A. No, that wouldn't cross my mind, no.

13

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Q. And notwithstanding that this child had a problem that is fatal, does that mean that this child died from that problem?

A. Well, it doesn't absolutely rule out, you know, any other possible causes, but it might not be digoxin. It may be anything under the sun he can die from.

Q. Well, referring to digoxin specifically, do you recall if it was brought to your attention that this child had a very strange pattern of digoxin administration?

A. I might have - you know, it might have been mentioned but it didn't come as a major concern to me.

Q. Well, could you turn to page 138 of the Hospital record?



BB6

1

A. Yes.

2
3 Q. Were you aware that after being
4 on digoxin essentially from the time of admission on
5 the 17th of July digoxin was apparently held on the
6 23rd of July, the 24th of July, one dose was held on
7 the 25th of July, both doses were held on the 26th of
8 July, and digoxin was held again on the next page on
9 apparently the 29th of July.

10 A. Yes. What is the question?
11 Q. Were you aware that digoxin was
12 held and then given to the child and then held and
13 quite often in the week prior to its death held?

14 A. Well, this is not unusual to
15 find in a chart. You know, you get a dose and then
16 it is held and then you get a dose again, so this
17 again would not raise any suspicion in my mind that
18 this is just a therapeutic manipulation to achieve
19 optimal dose of digoxin.

20 Q. So that wouldn't have sparked
21 any interest?

22 A. No.

23 Q. Will you turn to page 152.

24 A. Right.

25 Q. This one will be somewhat
difficult to find because it is in the middle of the



1

2

BB7 ICU pages that are not numbered but there is a
3 numbered page in the midst of that, a plain hand-
4 written page.

5

6

A. Yes. I don't know if this is
the page.

7

8

Q. Half way down that page it
says:

9

"Date of death 1 August/80".

10

11

A. Yes.

Q. "27 days". And right under
that it says "digoxin".

12

A. Yes.

13

14

Q. Did you recall seeing this
page when you flipped through the chart?

15

A. No, I don't.

16

Q. Do you have any idea what it
means?

17

18

A. It just may mean that he was
receiving digoxin.

19

20

Q. But you don't know what it
means?

21

A. No.

22

23

Q. Now, Doctor, in this report -
the preliminary report is found at page 21 of the
Hospital record and the final report at page 9 - in

24

25



BB8

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the preliminary report at page 21 the title is
Hypoplastic Left Heart Syndrome.

3

A. Yes.

4

Q. Now my understanding is that
is the main disease.

5

A. That is correct.

6

Q. And in a preliminary report
it is usually arrived at after the gross autopsy.

7

A. That is correct.

8

Q. Why did that become congenital
heart disease on the final autopsy report?

9

A. Well, it means the same thing.

10

Congenital heart disease is a much wider spectrum
of disease you can include, but basically hypoplastic
left heart syndrome just tells you specifically which
kind of congenital heart disease it is.

11

Q. Well, is there any reason why
you changed from the very specific to the broad in
the final report?

12

A. There is no special reason.

13

It is just for the purposes of coding the disease
under a category.

14

Q. And you decided to codify it
broadly?

15

A. That is correct, yes.

16

17



BB9

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Q. Did you discuss this case or did the resident to your knowledge discuss this case with any other clinicians?

5

6

A. I have no recollection whether it was discussed or not.

7

8

9

Q. When you review the chart would you generally look at the final medical impression in the progress notes? Would that be one of the things that you would look at?

10

11

12

13

A. Yes. That is obviously one of the things to look at. One problem at that time was that the final note may not necessarily be in the chart when we receive it.

14

15

Q. How long does it generally take you to receive the chart?

16

17

18

A. Well, we wouldn't start an autopsy without first seeing the chart. But we don't know when we receive it whether the chart is complete or it is incomplete.

19

20

Q. So you wouldn't know if you done it in this case?

21

22

A. Well, I am not sure if the note was there. You know, it may well be the note was in there.

23

24

25

Q. Could you turn to page 52 of



BB10

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the Hospital record?

2

A. Yes.

3

Q. That is the arrest note from
Dr. Izukawa.

4

A. Yes.

5

Q.. Do you recall reading that
note?

6

A. I don't recollect, no.

7

Q.. You don't recall?

8

A. I might have well read it,
but I don't know.

9

Q. Would the fact that the doctor
wrote "cardiac status appeared controlled" have made
any difference in what you did at this autopsy?

10

A. No.

11

Q. Am I correct in saying that
if you had - without assaying for digoxin this child --

12

A. Yes.

13

Q. You don't know one way or the
other if digoxin should have been or could have been
a cause of death for this child?

14

A. Well, I think that would be
really stretching it too far. You know, if a
condition like that I would for some reason order
digoxin at the same time I could order 10 or 12 other
drugs --

15



BB11

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Q. I understand.

2

3

A. -- to be screened. So from my knowledge of the chart and this child's condition I didn't think that was really indicated to order digoxin.

4

5

6

Q. No, my question is without a digoxin assay being taken on this child you can't tell me absolutely that this child did not die from digoxin intoxication?

7

A. I cannot.

8

9

10

11

12

13

Q. Now in Kristin Inwood's case you were not the supervising pathologist but you signed the final report?

14

A. Yes.

15

Q. For Dr. Phillips?

16

A. Yes.

17

Q. Now you have already told Miss Cronk that this particular case was under suspicion?

18

A. Yes.

19

Q. And you had been asked to rush the final report?

20

A. That is correct.

21

Q. Were you asked personally to

22

do this?

23

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BB12

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A. Well, it was really a decision made between myself and Dr. Mancer in terms of who is going to review what cases since I had already three cases on that list to do on my own and then I agreed to do one additional case and as it happened it was this particular case.

Q. Well, did you then go to Dr. Taylor?

A. Yes.

Q. And you told him that you needed this quickly?

A. That is correct, yes.

Q. You completed this in an evening as I understand it?

A. Yes.

Q. Because this was a case under suspicion did you review the progress notes in this case?

A. No, we did not review the chart, no.

Q. This was a very short chart?

A. Well, I don't think we had time to really go looking at the chart.

Q. Now in this report there was no, you will excuse the expression, main disease



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2

found at the top of the preliminary report, and
Dr. Taylor has told us that wasn't his practice.

4

5

The preliminary report is found at
page 36. The final report at page 20 of the Hospital
record.

6

7

Do you recall what you discussed with
Dr. Taylor of this matter prior to signing the final
report?

8

9

A. Well, I perhaps asked him what

the case was about.

10

11

Q. But do you recall that? My

question was do you recall?

12

13

A. I must have talked to him about

it but what in detail I can't recall, no.

14

15

Q. Now you have already Miss Cronk

at page 8589 over to page 8590 that page 2 of the
final report which points out that "Several factors
may have contributed to the death of this infant."

16

17

However, no clear cause is defined" was probably

not prepared when it was presented to you?

18

19

A. No, I think that must be an

error. I think I would not sign it if I didn't have
those two pages.

20

21

Q. So you had seen this page?

22

23

A. Yes, I did.

24

25



BB14

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Q. Did you agree with that finding?

3

A. Yes. I guess that there was

arrived at by mutual discussion with Dr. Taylor.

4

5

Q. So you discussed this with
Dr. Taylor?

6

A. That is correct, yes.

7

Q. And arrived at that conclusion?

8

A. Yes.

9

Q. Now you also seemed to indicate
that had it not been for the investigation that was
going on at the time --

10

A. Yes.

11

Q. -- you might have looked at
this child's death in a different light?

12

A. That is correct, yes.

13

Q. And if there was no suspicion
you wouldn't have considered this death unexplained?

14

A. That is correct.

15

Q. Did you know when this matter
was being presented to you that the EKG showed signs
of digoxin toxicity on admission, for that reason
was held?

16

A. I was not aware because I
haven't seen the chart of the patient.

17

Q. Well, Dr. Taylor --

18

19

20



BB15

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A. Yes.

2
3 Q. -- Dr. Taylor said that he
4 didn't know.

5 A.. Yes.

6 Q. He didn't know and I assume
7 that you didn't know?

8 A. Yes.

9 Q. Had you seen - and at the back
10 of the chart is Exhibit 113A which is a patient
11 incident report which indicates that Kristin Inwood
12 received a dose of digoxin that was not meant for
her?

13 A. Yes.

14 Q. Now Dr. Taylor didn't know
about this?

15 A. No.

16 Q. When he prepared this matter.
17 Do you know if you knew about this?

18 A. No, I did not.

19 Q. Would the fact that digoxin
20 was held upon admission for this child along with
21 the fact that this child received a dose of digoxin
22 meant for another child prior to death (in this
23 case about a day prior to death) make you look at
this death in a different light now?

24

25



DM.jc
CC 1

A. I think that at the time we were asked to comment on the case, I think we put it in the category of anatomical causes, immediate cause of death undetermined. I think from the findings, I don't think there would be much doubt about that the death was due to natural causes, or one could explain as being due to natural causes.

Q. Because you could explain it from natural causes, does that mean that this child could not have died from digoxin intoxication?

A. You cannot rule it out without any evidence for it, I would not consider it.

Q. Well prior to completing the autopsy, if you had known that this child had received a mistaken dose of digoxin after digoxin had been held, ordered held, would you have ordered a digoxin assay?

A. Well, we might have ordered it. The thing is again if that is what really happened you would not expect to find sky-high levels. In other words, you would find it if the therapeutic dose was administered, then you would just find it within that range.

Q. Is it something you would want to rule out?

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A. Well, if it was something

immediately prior to death you would think that such data would be useful, you would probably, you probably would do it, or you would have an interest in doing it.

Q. Well, to give you all the facts; this child was admitted and digoxin was held because of EKG findings which indicated digoxin toxicity?

A. Yes.

Q. At 5:30 in the morning, the

next morning, this child received a mistaken dose of digoxin and the child died at 3 o'clock the following morning.

A. Yes.

Q. Under those circumstances would you have wanted to rule out digoxin intoxication as a cause of death?

A. As I told you, I have not been involved in the initial supervision, so my involvement in this particular case is peripheral. You will have to ask these questions to whoever supervised the case. I will give you my own opinion about it, I would probably, if I was aware that this was the case, I would probably have ordered a postmortem digoxin level to be done.

MR. LABOW: Thank you very much, I have no further questions.



CC.3

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THE COMMISSIONER: Thank you.

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Mr. Tobias?

4

CROSS-EXAMINATION BY MR. TOBIAS:

5

Q. Dr. Cutz, my name is Tobias and I act for the family of Jordan Hines who is a child I believe you dealt with only on a peripheral basis?

7

A. Yes.

8

Q. With respect to the examination, or the evidence that you gave, sir, on October 4th, 1983, I believe my notes indicate that you had indicated that you had no recall whether it was yourself or Dr. Mancer who made the observations on Exhibit 198 regarding Jordan Hines, is that correct?

13

A. That's correct.

14

Q. At the time you were asked to prepare Exhibit 198, did you work in concert with Dr. Mancer or did each of you take a certain number of cases and work privately?

18

A. I believe the table, which as I say wasn't something which somebody asked us to prepare, but it was a means of facilitating discussions regarding these cases under suspicion. So that cases which I have directly been involved with then I would have made these comments as far as the levels of digoxin; as far as findings at autopsy; and as far as

24

25



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2 cause of death, I would have made those.

3 Now, in the cases which Dr. Mancer did,
4 he would be the one. In the cases that belong to
5 somebody else we might have given a judgment together.

6 Q. Now I understand your evidence
7 in terms of coming to the judgment together.

8 A. Yes.

9 Q. Did either you or Dr. Mancer
10 first take the information that you had on the
11 autopsy reports, et cetera, and review it individually?

12 A. Well, we would have had a copy
13 of the report which was available. I can't recollect
14 whether it was done individually or collectively.

15 Q. So you can't recall whether in
16 those particular cases you would have looked at the
17 reports together or individually?

18 A. No.

19 Q. Did you make notes, sir, on
20 your review of those cases?

21 A. No, we did not make notes.

22 Q. And so ---

23 A. I am sorry.

24 Q. I am sorry. You said you did
25 not make notes on your review of those particular cases?

A. Well, whatever comments we had



CC.5

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2 went on the report.

3 Q. How about Dr. Mancer, do you
4 know if he made notes?

5 A. I do not know.

6 Q. In respect of your own particular
7 cases there is nothing you can go to by way of notes
8 to try to refresh your memory as to whether or not
9 you reviewed the Hines' medical chart, or Dr. Mancer?

10 A. I definitely know I did not
11 review the chart for Hines.

12 Q. So that any review that went
13 into making a judgment call you think they would have
14 been done by Mancer, is that correct?

15 A. Well, I think probably what we
16 would have had available is the postmortem autopsy
17 report, and judgment as to the anatomical cause of
18 death would have been made on the basis of the report,
19 and this would be the only information we had.

20 Q. In respect of the Jordan Hines'
21 case, that judgment was a judgment that you and
22 Dr. Mancer made together?

23 A. Yes, I believe so.

24 Q. Now with respect to the questions
25 that you answered on October 4th, 1983, from Mr. Scott
in re-examination, I believe you had said that the

(2)



CC.6

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2 gutter sample, that contaminated sample that had been
3 taken from the pelvic cavity, would be useless in
4 terms of doing any assay for digoxin readings. Was
5 that your words, or were those Mr. Scott's words, do
6 I have that correctly?

7

A. No, I believe that is what I
7 said, but it is in the sense that if you are talking
8 about the serum level then this contaminated sample
9 cannot reflect the serum level.

10

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Q. In terms of the evidence that
you gave at the Preliminary Inquiry, do you recall
being asked about the effect of the contamination,
and do you recall indicating that the digoxin in that
particular sample would have been diluted?

A. No, I don't recall discussing
this in any detail.

Q. Well, perhaps I can assist you.
Mr. Commissioner, I am referring now to Volume 17 of
the Preliminary Hearing and it is at page 121.

MS. CRONK: That is Dr. Taylor's
examination.

MR. TOBIAS: I am sorry?

MS. CRONK: That is Dr. Taylor's
examination.

MR. TOBIAS: Oh yes, I am sorry, that



CC.7

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2 is Dr. Taylor's examination is the one I am referring
3 to and it is Volume 17, Mr. Commissioner.

4 THE COMMISSIONER: Did Dr. Cutz
5 testify at that Preliminary Inquiry?

6 MR. TOBIAS: He did, and I believe his
7 answer was he doesn't recall discussing in any detail
8 the question of contamination. I merely wanted to
9 read to him what Dr. Taylor had said to find out
whether he agreed with that, I won't read it verbatim.

10 Q. It is my understanding, Dr. Cutz,
11 that at the Preliminary Inquiry when Dr. Taylor was
12 asked about the effect of contamination, in his view
13 the sample would have been diluted. In other words
14 he was specifically asked whether it was the digoxin
15 and if it would have been diluted? His answer was,
16 yes. Do you agree with that, would that be one of
the effects of contamination?

17 A. Well, I think it would depend
18 as to what one defines as contamination. If one would
19 say that there is some water contaminating, coming
20 from, after the body is washed, and in that case it
21 would mean a dilution because you have, whatever fluid
22 is there becomes diluted by water which we introduce.
23 If you are talking about contamination from other
body fluids, then it could possibly go higher rather

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CC.8

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2 than lower. But it could go perhaps either way.

3 Q. So what you are saying is that
4 in the case of contamination by other body fluids you
5 would expect that one possibility of that contamination
6 is the digoxin reading would be higher as opposed to
7 lower, which is what we would get if it is diluted.
8 Do I understand your evidence correctly, Doctor?

9 A. Yes. What happens is digoxin
10 is in higher concentration in tissues, it bonds to
11 tissues, and then post mortem it may be released, it
12 gets into the other body fluids and then it depends
13 on where the tissue is taken from, you might have
14 different concentrations.

15 Q. Now in the Estrella case in
16 particular, it is my understanding that it was
17 contaminated with edema fluid, is that correct, is
18 that your understanding as well?

19 A. Yes.

20 Q. Now, would that have had the effect
21 of making the digoxin concentration higher, or would
22 that have the effect of diluting the digoxin?

23 A. I think it probably would be
24 higher.

25 Q. And that is why in your view
26 that kind of contamination makes it almost meaningless



CC.9

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2 to do an assay on that particular kind of sample?

3 A. If you want to determine what
4 the serum level is then I think that is useless.

5 Q. Fine. Now, you also indicated
6 Doctor, and I believe again this was to Mr. Scott in
7 re-examination. You recall that he asked you a
8 series of questions dealing with the state of your
9 mind when you prepared Exhibit 198. And you agreed
10 with him that it was being prepared at the request
11 of the police after it had been suggested to you that
12 there might be some digoxin involvement, and at that
13 time you believed a murder had taken place and that
14 digoxin was the murder weapon. Do you recall that
15 exchange?

16 A. Yes, I do.

17 Q. What I am concerned about
18 specifically is this. He indicated to you that in
19 light of the investigation, and the state of mind
20 that you and Dr. Mancer were operating in, is that
21 why Dr. Mancer's secondary reason in the Estrella
22 case in January became his primary reason for death
23 in March of 1981 when Exhibit 198 was prepared. Do
24 you recall that exchange?

25 A. I am sorry, would you repeat
the question.



CC.10

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Q. He suggested to you that in

January of 1981 at the time the autopsy was done on
Estrella --

5

A. Yes.

6

Q. -- Dr. Mancer only mentioned
digoxin intoxication as a secondary possibility.

7

THE COMMISSIONER: I don't think that
is quite what he said. Isn't that the famous line
that we are faced with all the time, if valid would
account for the child's death?

11

12

MR. TOBIAS: Yes, that is precisely

the one.

13

14

THE COMMISSIONER: I think he was

expressing some doubt about, but if it were valid I
don't think he had much doubt, maybe I am wrong.

15

16

17

18

MR. TOBIAS: Q. Doctor, did you read,
in March of 1981, would you have read the final
autopsy report on Janice Estrella, or would Dr. Mancer
have read that?

19

A. Dr. Mancer would have read it.

20

Q. So that at the time that

21

Exhibit 198 was prepared you would have had no
knowledge of what was in that report?

22

A. That is correct.

23

Q. You would have discussed it

24

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CC.11

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2 though I take it, with Dr. Mancer?

3 A. Yes.

4 Q. And come to a decision together
5 regarding Exhibit 198, or would Dr. Mancer have made
6 that decision?

7 A. I would think in that case it
8 would have been him since it was his case.

9 Q. So that you agree with me you
10 would have had very limited input into what to call it
11 in March of 1981?

12 A. That is correct.

13 Q. Now, all I am suggesting is
14 this, and I want to know if you agree with me; if we
15 wanted to know whether in fact Dr. Mancer elevated
16 it from a secondary reason to a primary reason; and
17 if we wanted to know why he did that, we would have
18 to ask Dr. Mancer not yourself, do you agree with that?

19 A. Yes.

20 Q. I mean, you wouldn't know what
21 went on in Dr. Mancer's mind, is that correct?

22 A. Yes.

23 MR. TOBIAS: Thank you. Those are all
24 the questions I have.

25 THE COMMISSIONER: Thank you, Mr. Tobias.

Mr. Shanahan?



CC.12

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MR. SHANAHAN: Yes, Mr. Commissioner,

I will start and I think I can be finished by the
break perhaps.

THE COMMISSIONER: All right.

CROSS-EXAMINATION BY MR. SHANAHAN:

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7

8

Q. Doctor, I act, my name is
Shanahan, and I act for Lombardo and Dawson families,
and you did not deal with Baby Lombardo?

9

A. No, I did not.

10

11

12

13

14

Q. If I could just take you through
some of the evidence that as I read it here with
respect to when Miss Cronk asked you about a report that
you prepared on the Dawson child; you indicated that
you had an opportunity to speak to Dr. Bunt I believe
it was beforehand?

15

A. That is correct.

16

17

Q. And as well as that you had an
opportunity to review her medical records?

18

A. Yes.

19

20

21

22

23

24

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Q. All right. So from reviewing
her medical records it would have been apparent
she was an 11 month old child and that was, as I see
it up until March that may well be about the eldest
child we were dealing with in this time period, she
was 11 months of age. You would have seen she had



CC.13

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2 a number of previous hospitalizations, the last being
3 in May, 1980, before her death.

4 A. Yes.

5 Q. And then she was in the
6 Hospital on the last occasion in July for five days
7 and she had not had any operation at that time,
8 although one was perhaps proposed, that being an
9 operation to correct the paralysis of the phrenic
valve?

10 A. Yes.

11 Q. So it would be fair to say
12 there had been no traumatic event that really had
13 brought her to the Hospital, I think failure to thrive
14 was the one event that had had her returned?

15 A. Yes, I believe that was so.

16 Q. And there had been no traumatic
17 event there, that is we will say another bout of
18 surgery while she was in the Hospital for that five
days?

19 A. Yes, I don't recall all the
20 details.

21 Q. I suggest to you as well,
22 Doctor, it would be obvious that she was on digoxin
23 and had been for along period of time; and that she
24 had in the last five days as well shown a lot of
25



CC.14

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2 vomiting and lethargy, the two things that if you
3 looked at her reports would stick out as well, is
4 that correct? Do you remember that, I know it is
5 hard, it may be asking you a lot to look it up. I
6 have seen them and the Commission has been through
7 them in other events.

8

9 When - I think it is the conversation
10 you had with Dr. Bunt, you indicated that some of the
concern had been, or suggestion had been, that in
fact there may be a concern about infection?

11

A. That is correct.

12

13 Q. And when you do this autopsy
you advised Miss Cronk that, first of all, as you
14 looked at the heart, and I am not going through
where you summarized it, it would be fair to say
15 that you really found, although you found anatomical
16 defects there originally, these defects had been
17 repaired?

18

A. Yes.

19

20 Q. And you were satisfied as well
too that there were no missed defects, that is as the
21 Hospital had analyzed it with their tests, that all
the defects had been found and they had all be
22 repaired and that repair had withstood normal day-to-
day living for Amber Dawson?

23

24

25



CC.15

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2 A. That is correct.

3

4 Q. Although it may not have been
5 the first area that you concerned yourself with on
6 autopsy, or on the autopsy, would it be fair to say
7 that even that in itself as you looked at a young
8 child that had died suddenly on the cardiac ward here,
9 was that in itself not surprising, but curious that
there was no cause of death here that you could find
immediately that was linked to her heart?

10

11

A. Well, you know, at that stage
you don't have all the data back.

12

Q. Yes.

13

14

15

16

A. Particularly you don't have
the microscopic examination, and so you form your
final opinion when all the things you ordered to do
come back. In fact in this case I thought at the
gross autopsy that we might have a cause of death.

17

18

Q. I am just going to get at that,
that is the abscess?

19

A. Yes.

20

21

22

23

24

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Q. But the heart itself, although
you may not have looked at it first, when you did
finally go in there, would be obviously of concern
because you might immediately find a cause of death
right there in the heart. I am suggesting to you you



CC.16

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2 don't find anything there, and in fact maybe to your
3 surprise you find that everything has been repaired
4 and is still in working order?

5 A. Well, this is in terms of the
6 septal defects which were repaired.

7 Q. Yes.

8 A. But the pulmonary abscess, the
status of the myocardium --

9 Q. Yes.

10 A. -- which in fact in this case
11 it did show quite extensive fibrosis.

12 Q. Yes, but you did indicate to
13 Miss Cronk that you didn't attribute them as the
cause of death?

14 A. Well, it wouldn't be immediate,
15 it would certainly be a serious finding.

16 Q. But you did find in fact an
17 abscess, what you thought was one?

18 A. Yes.

19 Q. And you thought then, as you
20 explained to Miss Cronk I believe, that you thought
21 perhaps this abscess might be the key to this, because
22 after all an abscess is not uncommon when you have
23 that phrenic nerve paralysis, and if you have this
24 abscess it would explain the rupturing and perhaps

25



CC.17

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2 the release of the infection generally around the body?

3 A. That is correct.

4 Q. Then the tests come back at
5 some point in time and it is apparent that it is not
6 an abscess because it is not an infected area?

7 A. Yes.

8 Q. And therefore now, sir, I suggest
9 to you that one, the obvious area of heart problem
10 has been resolved as there is no particular heart
11 defect. And the second area that Dr. Bunt has
12 indicated to you might be their conjectured cause of
13 death, that is infection has also been eliminated?

14 A. Yes.

15 Q. Now then, sir, you do conclude
16 here, and you pick up on a word that Mr. Scott has
17 picked up on, you conclude that there was no
immediate anatomical cause of death, there was no
problem in the anatomy that you could see?

18 A. That is correct.

19

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Q. Well then, sir, in fairness,
in the other areas you indicated that a drug screen
is not standard in a coroner's case, that a coroner
generally will ask you to perform a drug screen?

5

A. That's right.

6

Q. All right. But he didn't ask
in this situation?

7

A. No, he did not.

8

Q. Of course you are not bound
by what he may ask or direct you to, if you wished to
do a drug screen on Amber Dawson, you could have done
it?

9

A. Yes, you know, if I had any
suspicion of anything particular I might do it, yes.

10

Q. All right. A drug screen, what
it may involve here, you may have told other witnesses,
but I certainly don't recollect it, how wide is that.
Are we talking about hundreds of drugs or every known
drug or the known drugs this child was on?

11

A. Well, let me see. It would
be limited by, let's see if it was done at our
Hospital it would be limited by the types of assays
they do. Now, if it would be done in the Forensic
Sciences, that they may do much more extensive drug
testing which they would more or less devise.

12

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Q. All right. But generally you do a drug screen of your own initiative, would you do a screen of the known drugs that that child was to be on?

6

A. That would be one of the things you would have to include on a request, which of the drugs the patient received.

7

Q. All right. So, in other words you would take samples and you would ask the appropriate departments to test for the drugs and you would indicate what drugs?

12

A. Yes.

13

Q. And in this case with Amber Dawson being on digoxin, if you had had that notion you could have indicated you wanted the digoxin done on the screening?

16

A. Yes, if I had any reason to believe this was a problem.

18

Q. All right. Sir, you have had this referred to you under a Coroner's Warrant?

20

A. Yes.

21

Q. Dr. Reynolds when he did the death summary indicated, that is in the notes as well, there was no immediate cause or explanation for the cause of death?

24

25



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2 A. Yes.

3

4 Q. There has been no problem
5 with the heart anatomically and there hasn't been
6 any link up with respect to the infection that Dr.
7 Bunt suggested may be the cause. At this point in
8 time would it not have been an area where you might
9 say to yourself here that some sort of drug testing,
10 something further should be done?

11 A. Well, I think as far as the
12 autopsy goes I thought I more or less completed my
13 obligation by indicating to the coroner what we found
14 and if he has any further suspicion or he's not
15 satisfied he's the one who investigates the matter,
16 it's not me.

17

Q. Yes.

18

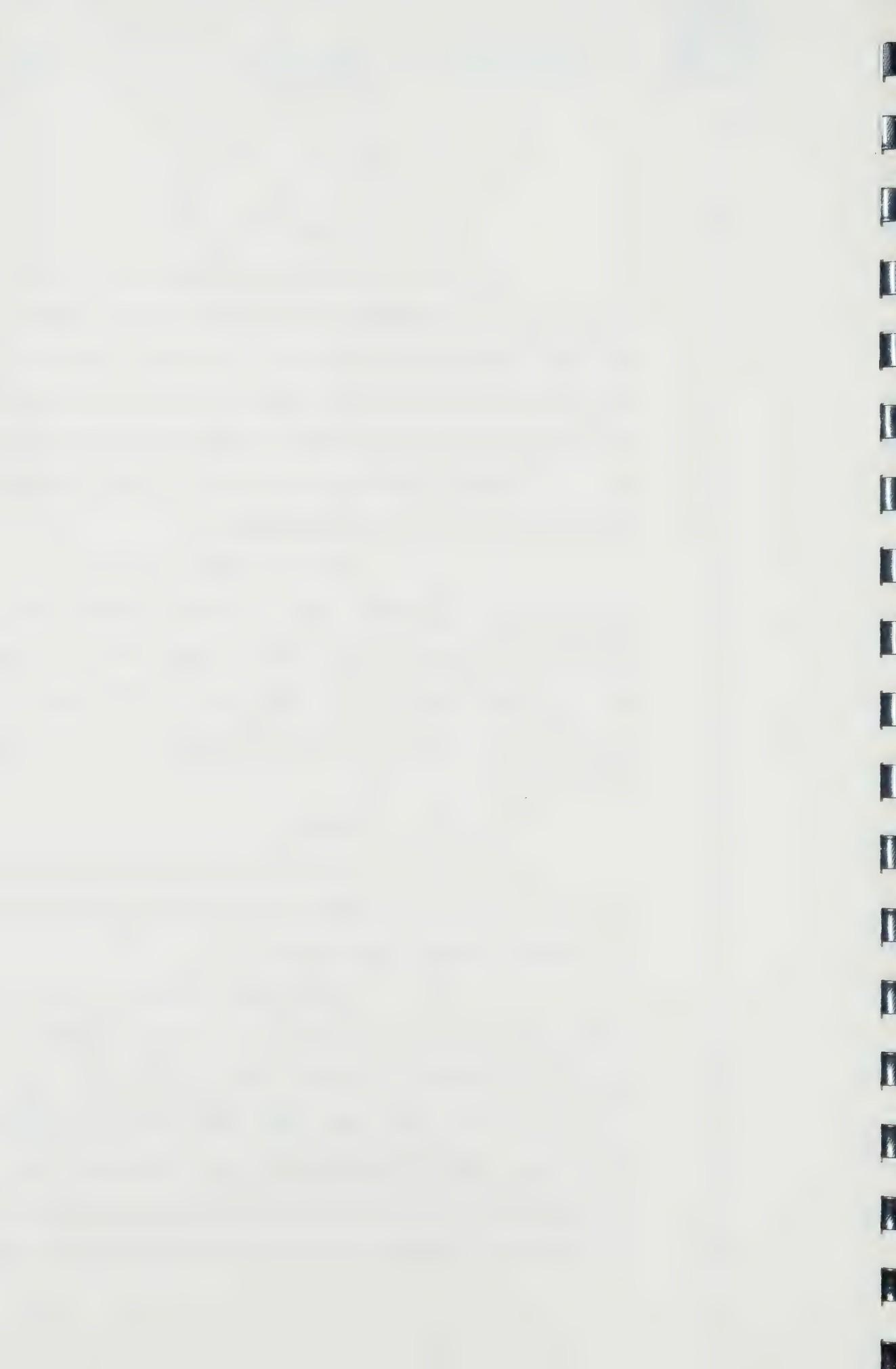
19 A. Then he should maybe enlarge
20 it. But I left it at this stage where I summarized
21 my findings and my conclusions.

22

23 Q. Up to this point in time and
indeed a lot later into March, as I have looked at
reports prepared by yourself and others, none that
I can recollect and others here may have found some,
had you put down or anybody at Sick Children's put
down that there really was no immediate explanation
for the death, usually we had something, we had some

24

25





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2 transient cause, we had SIDS, we had something, but
3 there was nothing here. Wasn't that surely un-
4 satisfactory even to yourself as a pathologist not
5 to be able to say the whys and wherefores of an
6 11 month old dying?

7 A. Well, I think there are cases
8 where you cannot explain. I mean, that would be
9 untrue to say that you can explain everything. So,
10 there are cases where you don't have an apparent
11 cause and in this particular case there were
12 contributing factors which I mentioned, one is the
13 presence of congenital heart with the myocardium
14 fibrosis and the paralyses of the diaphragm which can
15 be associated with sudden death per se.

16 Q. But you do call them
17 contributory and you did conclude there was no
18 immediate cause that you could see?

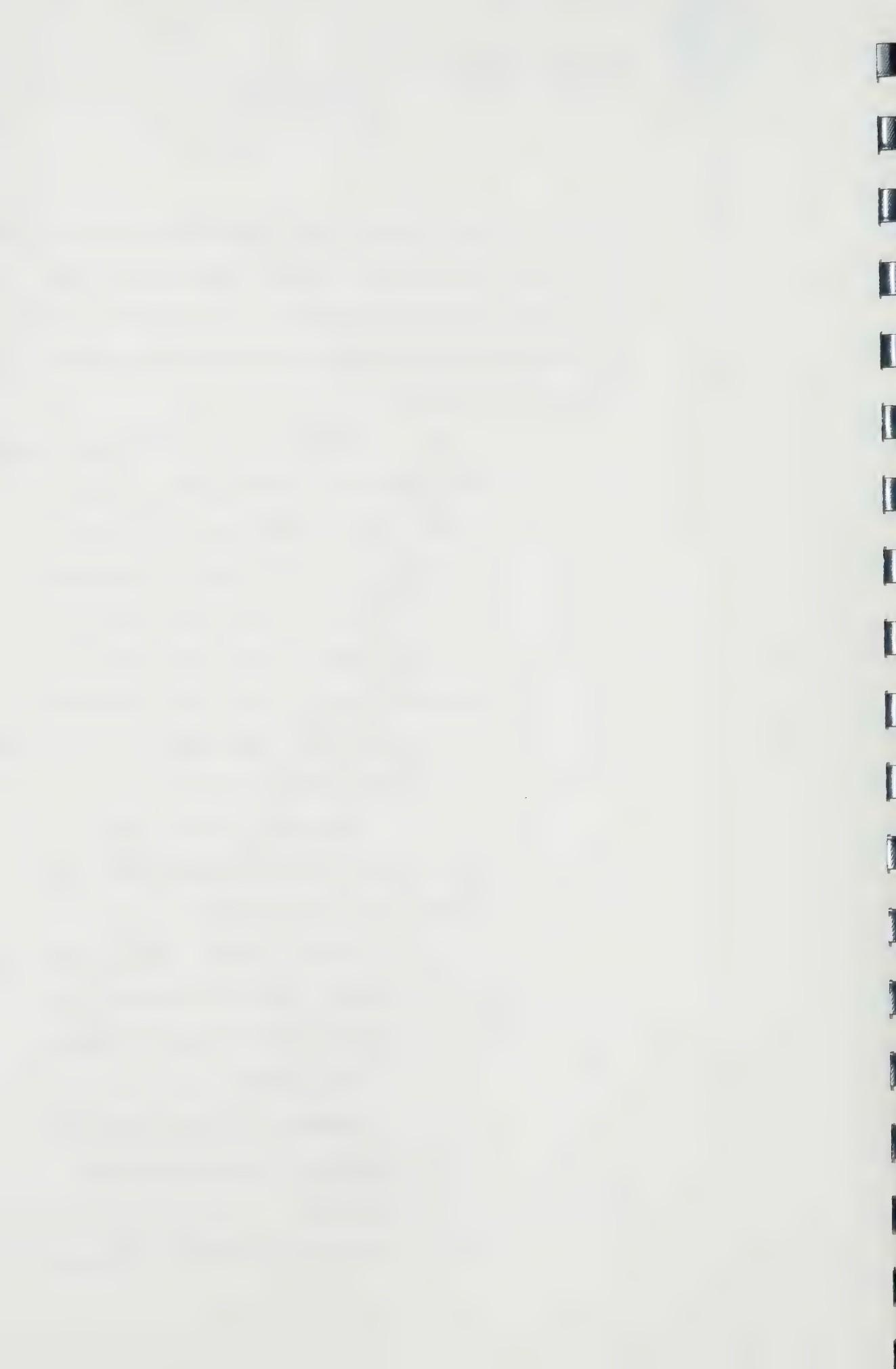
19 A. That's right. Well, this is
20 the speculation. I cannot say this finding, or
21 whatever anatomic finding is the cause of death.

22 Q. All right.

23 A. Because I didn't have it.

24 MR. SHANAHAN: I have two more
25 questions, Mr. Commissioner.

Q. You did order a digoxin





1

5 test on Pacsai as I recollect it?

2

A. Yes.

3

4 Q. I think you said that the
5 reason you ordered it in Pacsai was that his terminal
6 events caused you some sort of concern. Am I right
there so far?

7

A. Yes, the clinical data which
8 were given in the chart, yes.

9

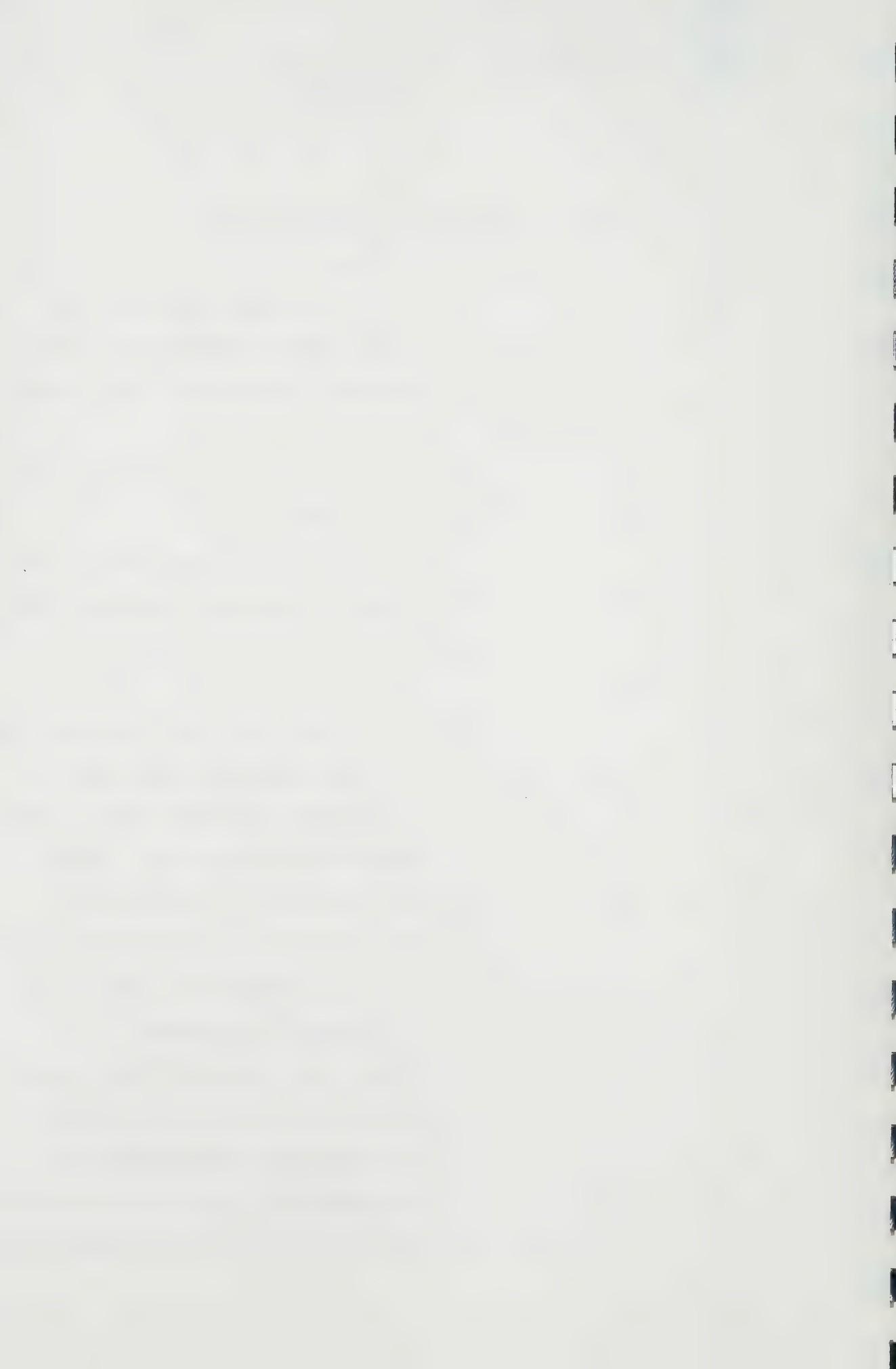
10 Q. Did I understand too as well
that the manner in which he died, his terminal events?

11

A. No, I did not analyse it in
12 that light, no.

13

Q. I see. And then finally, sir,
14 when you were dealing with the police out there in
15 March and you were preparing a list for them, I would
16 have thought as I looked back that it was rather
17 arbitrary to stop where you did. I would have
18 thought that you had done here an autopsy on a young
19 child, you had no immediate anatomical cause of
20 death, Dr. Bunt's suggestion with respect to
21 infection had been ruled out. I would have thought
22 here with digoxin in the air and with this child
23 having received digoxin that her name would have
24 stuck out like a sore thumb and you would have pointed
25 out to the police perhaps we had better go back even





1

2 further to the Baby Amber Dawson?

3 A. No, I didn't think about the
4 case at all.

5 Q. No, I know you didn't.

6 A. At the time.

7 Q. I know you didn't. But I am
8 saying to you, I am suggesting this would have been
9 a case that really would have and should have stuck
out in your mind here?

10 A. Well, I don't know what to
11 say.

12 MR. SHANAHAN: All right. Thank you
13 very much, that's all the questions I have.

14 THE COMMISSIONER: Thank you. We
15 will take 15 minutes.

16 ---Short recess.

17 ---On resuming.

18 THE COMMISSIONER: Yes, Mr. Shinehoft.

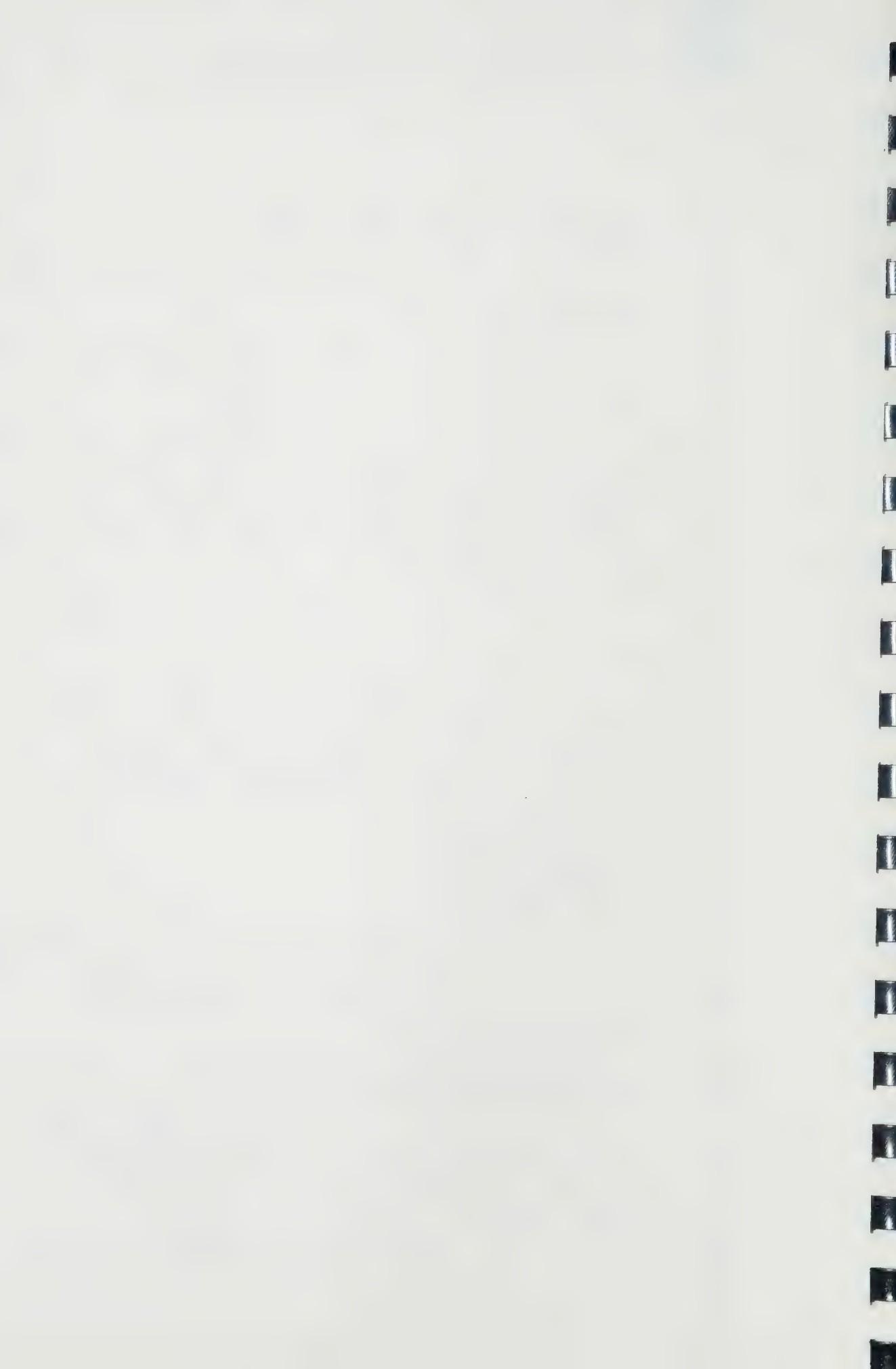
19 MR. SHINEHOFT: Thank you, Mr.
Commissioner.

20 CROSS-EXAMINATION BY MR. SHINEHOFT:

21 Q. Dr. Cutz, my name is Jack
22 Shinehoft and I am the lawyer for the parents of
23 Kevin Pacsai.

24 Now, Doctor, you told us that his

25





1
2 particular case was a coroner's case, is that
3 correct?

4 A. That is correct, yes.

5 Q. And as such that you personally
6 would conduct the autopsy?

7 A. That's correct.

8 Q. Do you recall how long it
9 took you to do that autopsy?

10 A. I can't exactly tell you but
11 probably not very long. Maybe one and a half, two
12 hours.

13 Q. I understand that autopsies
14 can vary from two to six hours approximately, is that
15 correct?

16 A. Yes.

17 Q. And you don't keep any
18 notations as to when the autopsy commenced and when
19 it was terminated?

20 A. I don't usually keep that
21 sort of a thing.

22 Q. You also told us, Doctor, that
23 you did it on the basis of a Coroner's Warrant, is
24 that correct?

25 A. Yes.

26 Q. And the last time you were



1

2 here you tried to find the warrant but you couldn't
3 find it.

4

A. Yes.

5

Q. Have you had any luck since?

6

A. Yes.

7

Q. Where is that warrant, sir?

8

A. No, I have the original and
I think the copy of it was given to Miss Cronk at one
time.

9

MS. CRONK: If that is so I will get
a copy for you.

10

MR. SHINEHOFT: Yes. May I look at
the original, Doctor.

11

Miss Cronk, will that be filed as
an exhibit to these proceedings?

12

MS. CRONK: Well, it hasn't to date
but if you would like to do so, Mr. Shinehoft, perhaps
you can do it now.

13

MR. SHINEHOFT: Yes. May I, Mr.
Commissioner, show the doctor what purports to be
a photocopy of Warrant for Postmortem Examination.
Doctor, is that the particular warrant under which
you conducted the autopsy?

14

A. That's correct.

15

MR. SHINEHOFT: If I might, Mr.

16

17



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2 Commissioner, if that could perhaps be Exhibit 106D.

3

4 THE COMMISSIONER: Oh, 106D. Do you
5 want it in with -- A Coroner's Warrant wouldn't
6 ordinarily go in with the medical records, would it?

7

8 THE WITNESS: No, it would not.

9

10 THE COMMISSIONER: So, I think it had
11 better have another number, 207.

12

13 ---EXHIBIT NO. 207: Warrant for Postmortem Examination.

14

15 MS. SYMES: Excuse me, what is the
16 date on that Coroner's Warrant, please.

17

18 MR. SHINEHOFT: I believe it is the
19 12th day of March, 1981. Is that correct, Doctor,
20 you have the original.

21

22 A. Yes, that is correct, yes.

23

24 Q. Now, as I recall from your
25 evidence, Doctor, that you previously gave, you
considered three possibilities as the potential
causes of death for this child, is that correct?

18

A. Yes.

19

20 Q. They were as follows:
21 infection, a problem with the conduction system and,
22 thirdly, digoxin toxicity. Is that correct?

23

A. Yes.

24

25 Q. And then you developed a fourth
possibility and that is the question of potassium.



1

2 When did this develop in relation to the first three
3 possibilities that I have mentioned?

4 A. Well, this is actually one
5 of the things mentioned on the warrant, which is
6 brought to my attention, that there are high potassium
7 readings. They were high potassium readings of an
unexplained nature.

8 Q. Did you consider that as a
9 primary factor in determining the cause of death
10 because, I will tell you why, Doctor, on your
11 previous examination at Volume 42 at page 8539,
line 12, you stated:

12 "Yes, I was considering these various
13 factors: infection, the conduction
14 system defect and the possibility of
15 digoxin toxicity, yes."

16 A. Yes.

17 Q. And then you go on to
mention the question of potassium. Did you consider
18 that fourth possibility at the same time you were
19 considering the first three or did you come to that
20 concern later on?

21 A. Well, I think since we knew
22 what the results of the potassium were and the way
23 we interpreted it, you know, I did not consider it
24

25



1
11 at that time as being a significant factor.

2
3 Q. You had never come across
4 potassium intoxication before, had you?

5 A. Well, not personally but, you
6 know, there are cases of potassium intoxication, yes.

7 Q. So, it was some time later that
8 you developed or thought about this fourth possibility,
9 is that correct?

10 A. Yes.

11 Q. Do you recall exactly when
12 you did think about the question of potassium?

13 A. Well, I think that was one of
14 the, I would say, the original possibilities.

15 Q. Yes.

16 A. But maybe in subsequent
17 discussion about it since we have discounted it,
18 I didn't bring it up.

19 Q. Thank you, Doctor. You also
20 stated that on your previous examination you took
21 the sample, you drew the sample from the inferior
22 vena cava, is that correct?

23 A. That is correct.

24 Q. Is that the normal site to
25 draw such a sample?

26 A. Well, it is the usual site that

27

28



1

I take for blood cultures. It may not be the identical site for toxicology but it is one site where you can obtain large amounts of blood.

4

Q. Is this often used to obtain blood cultures for purposes other than, say, a bacteriological examination?

7

A. Yes, that would be the usual site, yes.

9

Q. You also said that you initially became involved with this case through a telephone conversation with Dr. Fowler?

11

A. No, Dr. Fowler was the first who made me aware of the case.

13

Q. I believe you said in your previous examination:

15

"Dr. Fowler called me and told me they did not have a firm clinical diagnosis as to the cause of death."

18

A. Yes.

19

Q. Do you recall that?

20

A. Yes.

21

Q. Is that a normal thing to happen?

22

A. Well, I think Dr. Fowler had some other concerns as well. Like, he had some, he

24

25



1
2 made me to understand he had some problems with the
3 parents which I don't know what the actual ---

4 Q. I understand that.

5 A. Yes.

6 Q. You have said that before. But
7 I meant only in respect of having a cause of death
8 from which there was no clinical diagnosis. Is that
abnormal in your experience?

9 A. Well, it would not be abnormal
10 except, you know, it is not that often that the
11 clinicians would call us directly.

12 Q. Who would contact you
normally, Doctor?

13 A. Well, if it is some unusual
14 case, or at least what the clinicians would consider
15 to be an unusual case, they might contact us directly
16 or ask a resident to contact us or write a note.

17 Q. As I understand it, Dr. Fowler
18 was the Ward Chief for the month during this baby's
death. You have indicated that it is unusual for
19 him to have called you directly, is that right?

20 A. Well, that is the first time
21 as far as I can recollect Dr. Fowler calling me.

22 Q. Was it the first time a Ward
23 Chief ever called you?

24
25



Cutz, cr.ex.
(Shinehoft)

14

1 A. No, it was not, it wouldn't
2 be the first time, but Dr. Fowler it is the first
3 time.

4

5 Q. So, you would consider this
6 very unusual?

7

8 A. Well, it's not unusual except
9 that he expressed some concerns about the case.

10

11 Q. And when was the first time,
12 Doctor, that you had a conversation with Dr. Costigan,
13 do you recall?

14

15 A. Well, the first contact with
16 Dr. Costigan was on the 18th.

17

18 Q. And as I recall, you were
19 unaware that he had ordered an antemortem sample
20 and that he was unaware that you ordered a postmortem
21 sample, is that correct?

22

23 A. I didn't know whether he
24 ordered it or not.

25

26 Q. Well, you have subsequently
27 found out that he did order an antemortem sample?

28

29 A. Yes, yes.

30

31 Q. Dealing with the sample. You
32 are aware of the reading that came out of that sample?

33

34 A. Well, I don't recall he telling
35 me the actual number but later on, you know, I learned

36

37

38

39



15 what the number was.

Q. All right. Do you recall what
3
that number was, Doctor?

A. I think it said more than,
5
larger than 10.

Q. Larger than 10 and insufficient
6
sample for further dilutions?

A. Possibly, yes.

Q. Would that be consistent in
9
your experience and the information that you have
10
garnered since these events with a postmortem reading
11
of 26?

A. I presume it would, yes.

Q. And you are aware of the
13
therapeutic dosages of the drug?

A. Yes.

Q. And is it fair to say that
16
it is 0.5 to approximately 2.5?

A. Yes.

Q. Is that your understanding?

A. Yes.

20 THE COMMISSIONER: I am sorry, are
21
those the dosages or are those the levels?

22 MR. SHINEHOFT: Therapeutic levels.
23
I'm sorry, therapeutic levels, Mr. Commissioner.

24

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Q. Now, you also indicated the last time you gave evidence, Doctor, that a baby had a potassium level of 11.6 milli equivalents per litre?

A. Yes.

Q. And you indicated that 24 hours after death you found that reading of no particular significance?

A. Yes.

Q. Now, is that because, Doctor, that after death the potassium in the cells are released and they flow into the blood?

A. Yes.

Q. And therefore you would get after death an elevated level of potassium because of this breakdown in the cells?

A. Yes.

Q. Okay, Doctor, if I could refer you to the autopsy report and as well the chart that you made, or the note that you made on the preliminary autopsy report, which is at page 94 of Exhibit 106. If you could just turn to that, Doctor.

A. Excuse me, what page?

Q. Page 94.

A. Yes.



1

2

Q. In the second paragraph in the
second sentence you say - well, at the end of the
first sentence you say:

4

"In particular the heart was anatomically
normal. However, the conducting system
has not yet been examined."

7

Is that correct, is that what you said?

8

A. Yes.

9

Q. What did you mean by that,
Doctor?

10

A. Well, what it meant was that
at that particular time we did not have, or the
examination which would be required to examine the
conduction system was not performed.

14

15

Q. Okay. But would I be
incorrect in assuming that you had intended to do
this?

17

A. Yes. If that became a very
significant factor in this case then we would have
done it, yes.

19

20

Q. And I understand there are
different types of conduction tests that can be done,
is that correct?

22

23

A. As far as a pathologist, you
know, what he has to do is serially section, which

24

25



18

1 2 would require up to 20,000 sections.

3 4 very time consuming arduous type of task, right?

5 6 A. Yes.

7 8 Q. But it can be done, is that
9 10 correct?

11 12 A. Yes.

13 14 Q. But I also understand, Doctor,
15 16 that if you don't have the time to spend to get
17 18 20,000 sections that you might do it with a few
19 20 hundred sections?

21 22 A. Yes.

23 24 Q. And try to come to some
25 26 conclusion based on the sections that you do do, is
that correct?

27 28 A. That is correct, yes.

29 30 Q. Is that what you had in mind
31 32 when you wrote that?

33 34 A. Yes, I think it could be done
35 36 partially and if you don't find anything on this
37 38 partial examination then you would do a total.

39 40 Q. Is there a reason why the
study wasn't done, Doctor?

41 42 A. Well, the study wasn't done
43 44 because subsequently the heart tissue which we had

45

46



1
2 saved for that test has been turned over for
3 toxicology.

4 Q. I see. Now, you had indicated
5 that there was a question of high potassium levels
6 of this baby. That would be related, would it not,
7 Doctor, to the kidney function or renal function?

8 A. Well, renal or adrenals, yes.

9 Q. Right. So, would it be fair
10 to say that you gave particular attention to that
part of the autopsy when it came to do that?

11 A. Yes.

12 Q. And that you were somewhat
13 careful in doing that portion of the autopsy test?

14 A. Yes.

15 Q. Correct me if I'm wrong,
16 Doctor, but I believe you came to the conclusion
17 in your report that the kidney was basically normal
18 and the adrenals were anatomically normal, is that
correct?

19 A. That is correct, yes.

20 - - - -
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2 Q. We have had some discussion or
3 you have with the question of transient adrenal
4 insufficiency.

5 A. Yes.

6 Q. Is that correct? And there is
7 another phrase for that, transient hypofunction of
8 the adrenal cortex.

9 A. Yes.

10 Q. And they are one and the same?

11 A. I believe so, yes.

12 Q. And I believe you said,
13 Doctor, that you are somewhat unfamiliar with the
14 pathology of this condition. Is that a fair state-
15 ment?

16 A. Well as far as I am aware
17 there is no pathological description of the condition.

18 Q. Well, Doctor, if I were to tell
19 you that an endocrinologist feels that there is,
20 would you disagree with me?

21 A. I could not disagree. I would
22 have to see what that evidence is.

23 Q. And if I were to tell you that
24 the pathology would be some anatomically abnormality
25 of the adrenal gland either in size or architecture,
would you dispute that?



Cutz, cr.ex.
(Shinehoft)

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A. Well, there are a number of conditions of the adrenals which are better defined than this transitional --

5

Q. No, but I mean --

6

7

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A. -- insufficiency, but you do have changes. As far as I'm aware this particular condition doesn't have detectable morphological changes by the usual examination.

9

Q. . . But if I were to tell you that there are some endocrinologists that say that there are, are you in a position to disagree with that?

12

13

14

A. I would have to see the evidence to see whether I agree or not. I have not seen a case in which this came up as a diagnosis.

15

Q. Would I be fair to say that this is a very unusual condition?

16

17

A. I would think it must be very rare, yes.

18

19

Q. Have you ever seen it in your life?

20

A. No, I have not.

21

Q. Have you ever heard about it until Dr. Bain made his report?

22

A. Well, it is a clinical diagnosis so it is not something which we would ordinarily be

24

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involved with.

3

Q. Right.

4

A. But Dr. Bain is a very

5 experienced clinician.

6

7

Q. Yes, I appreciate that, and we
are going to hear from him.

8

A. Yes.

9

Q. But my question quite
specifically is until Dr. Bain made his report and
10 I believe you had a chance to look at that; is that
11 correct?

12

A. No, I haven't seen the report.

13

Q. You have never seen the report?

14

A. No.

15

Q. Had you ever heard of this
condition before?

16

A. No.

17

Q. If I could refer you, Doctor,
to Exhibit 106A, I believe it is the final autopsy
report. Do you have that in front of you?

20

A. Yes.

21

Q. Could you turn, please, to
page 3 of that report? That is the third page but
not page 3 of the report itself. It is actually
23 page 1 of the report.

24

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Have you got that?

3

A. Yes.

4

Q. It is entitled at the top
"Coroner's Act, Province of Ontario", and it is
"Report of Postmortem Examination".

5

A. Yes.

6

Q. If you could turn, Doctor, to
the third section, 3-1, and there is the question of
how nourished and you will see you wrote the word
"well" beside it.

7

A. Yes.

8

Q. How do you determine whether

9 a baby is or is not well nourished?

10

A. Well, it is by just the
appearance. If the body and the appearance of the
body is consistent with a given age.

11

Q. So do you do a growth chart,
for example, on the child to see if it fits within
12 the normal parameters of the chart?

13

A. Yes, if there is a question
that it is something, you know, doesn't correlate
then you might look at the chart but if the weight,
the length corresponds to what the infant is supposed
to be as far as age, then you would think this is
within normal limits for that age.

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Q. Right. The calculations would appear that the child gained 25 grams per day. Would you consider that normal, Doctor?

5

6

7

A. Well, again I am not expert in this sort of particular area to tell you what the normal requirement is.

8

9

10

Q. Well, you must have had something in your mind, Doctor, when you wrote on the report itself that the child was well nourished?

A. Yes.

11

12

13

Q. There must have been something that you addressed your mind to to come to that conclusion?

14

15

16

A. Well, I think this particular thing refers to three possibilities: is the body malnourished, is it normal or is it fat.

Q. Yes.

17

18

19

A. So this is, you know, this qualifies it as being within the normal limits without going further as far as...

20

21

22

Q. So you are saying that it is normal or well? I mean is there a difference between the two, Doctor?

23

24

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A. Well, it would imply that it is within normal limits what would be expected.



Cutz, cr.ex.
(Shinehoft)

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Q. I see. Did you say, Doctor,
that you had never read Dr. Bain's report?

A. I heard about it and I actually
was shown a page of it the other day here.

Q. But you never really read the
report?

A. No.

Q. Now you are not in the position
to comment on the report?

A. No.

Q. Now you have also indicated
previously, Doctor, that if the digoxin levels are
accurate then that could account for the child's
death?

A. Yes.

Q. Now assuming that these levels
are accurate, and you may not be in a position to
answer this question: would you think it would be
as a result of therapeutic administration of the
drug?

A. It is hard to say.

THE COMMISSIONER: Not very good
therapy if that is...

MR. SHINEHOFT: Q. Would you think
it could be as a result of accidental administration



EE7

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of the drug?

3

A. Yes, it is a possibility, yes.

4

Q. Do you think it could be a
result of a deliberate administration of the drug?

6

A. That is also a possibility, yes.

7

Q. And just in conclusion, Doctor,
you feel that if that level can be supported - in
other words, if there is nothing feloniously wrong
with that level, then you feel that the cause of
this child's death is digitalis intoxication; is
that correct?

12

A. Well, if the finding sticks -
in other words, there is no longer an explanation
as far as how he can get such a level under normal
circumstances, then I think that would have to be
the conclusion, yes.

16

Q. And that was your conclusion
at the time you prepared this report, and that
conclusion is not changed today, has it?

19

A. Not so far, no.

20

MR. SHINEHOFT: Thank you very much,
Doctor.

21

THE COMMISSIONER: Miss Thompson?

22

MISS THOMPSON: We have no questions
of this witness.

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THE COMMISSIONER: Mr. Ortved?

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MR. ORTVED: I just have a couple
of questions.

5

RE-EXAMINATION BY MR. ORTVED:

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7

Q. Dealing with the Baby Amber
Dawson first, Dr. Cutz, you recall being questioned
about that child by Mr. Shanahan here?

8

9

10

11

12

13

A. Yes.

Q. And specifically, Mr. Shanahan
asked you whether or not it might have been appropriate
to include Amber Dawson on that list that have been
shown and filed here as an exhibit. Do you recall
those questions?

14

A. Yes, I do.

15

16

17

Q. Now just dealing with that
list firstly, Exhibit 198, were you asked to
prepare a list of potential suspicious cases for
the police?

18

A. No.

19

20

Q. What did you understand to be
your function on March 24th and 25th of 1981?

21

22

23

A. Well, we received a list of
names of patients who died, and we were asked to
complete the autopsy reports on the patients in which
autopsies were performed.

24

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Q. And did you understand it to
be your function to go outside of the list of
children that were presented to you by the police?

5

A. No.

6

7

8

9

Q. And in fact what you did was
prepare a list detailing exactly the same children
as on the list presented to you by the police but
expanding it to include information taken from the
autopsy reports? Correct?

10

A. That is correct, yes.

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Q. And insofar as Dawson was
concerned, to deal with the specific question, what
was your view as to whether the cause of death in
that child's case was natural or unnatural?

A. No, I think at the time of
the autopsy I had no question in my mind that that
was not a natural death.

Q. You had no question in your
mind that it was not natural. What is that to say?

A. Well, it is to say that I
didn't have any suspicion about it and I thought that
the cause of death even though I couldn't pinpoint
it, it was due to natural causes.

Q. Thank you.

Now I take you to the Inwood case. In



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particular I understand that your function in relation to Inwood was really fairly peripheral. You really just reviewed and signed out the report that Dr. Phillips had commenced; is that correct?

A. That is correct.

Q. And the additional work that was completed on that report in the period of March 24th and 25th was really performed by Dr. Taylor for the most part?

A. Yes, Dr. Taylor together with me.

Q. You reviewed his work?

A. Well, we reviewed the microscopic slides together.

Q. All right. I am referring to the transcript of your testimony of your examination by Miss Cronk in Volume No. 42, page 8595 in which you reviewed the findings set out on the autopsy report and specified certain of those findings, in particular cardiomegaly and focal myocardial necrosis as being possible contributing factors.

Would that be fair?

A. Yes, that is correct.

Q. I am summarizing your testimony, but would it be fair to say that your conclusion as



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of March 24th or 25th was that perhaps the cause of death couldn't be specified and therefore this case should not be crossed off the list of cases to be further investigated?

6

A. That is correct, yes.

7

Q. But insofar as any postmortem digoxin level was concerned, taking you back to March 13th, the day of that child's death, and trying to put yourself in the shoes of Dr. Phillips who performed the autopsy, would it be fair to say that the Inwood case really doesn't fall into the same category as, for instance, the Pacsai case?

13

A. Yes.

14

Q. And that really as of March 13th, 1981, there wasn't the same atmosphere of suspicion concerning possible maladministration of digoxin as existed as of March 24th and 25th?

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A. Yes.

18

Q. And it was really that atmosphere of potential intentional digoxin intoxication that sparked, for instance, your request for a postmortem digoxin level in Miller, for instance?

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A. No, I was not considering deliberate type of...

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Q. Well, at least those elevated results. Right? That is what prompted you to run the postmortem tests on Miller?

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A. That is right.

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Q. And those pre-conditions didn't exist as of the date of Baby Inwood's death on March 13th?

8

A. That is right.

9

Q. And I take it that if there is a patient incident report indicating an accidental misadministration of a drug, is that something that comes down to the Pathology Department with the Hospital chart?

10

A. It is not necessarily the case.

11

As I mentioned before, we are never certain if all the - if the chart is complete because it is loosely bound.

12

Q. Yes.

13

A. Or it is not bound at the stage we get the chart.

14

Q. Let me just ask you to assume a sequence of events.

15

Assume for a moment that there was an accidental administration of a therapeutic dose of digoxin to Kristin Inwood at 5:30 in the morning,

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and subsequently a level were taken for digoxin, and that came back at 2.6 and that level was taken at 9:00 a.m., three and a half hours after the administration, and that level was at 2.6. Assuming you knew those facts and you were the pathologist performing the autopsy, would those facts in and of themselves suggest to you that there might be a concern for digoxin intoxication and a postmortem digoxin level should be run?

10

A. I wouldn't think so.

11

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MR. ORTVED: Thank you. Those are my questions.

13

THE COMMISSIONER: Well, Miss Cronk?

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MS. CRONK: Sir, I am obviously prepared to start now but it is very clear that I won't be finished by 4:30 nor I might say within 15 minutes. I would expect to be 30 minutes to 45 minutes with the Doctor.

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THE COMMISSIONER: Are you in great trouble tomorrow, Doctor? You will be available? All right. I think we will leave it.

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MR. TOBIAS: Mr. Commissioner?

THE COMMISSIONER: Yes?

MR. TOBIAS: If I might make a request before we break, it seems to me that



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2 starting tomorrow we are going into a new area or
3 an area that we have not covered before. We start
4 to get into Mr. Cimbura and Dr. Ellis and Dr. Soldin,
5 and I would take it that Commission Counsel intends
6 to go into the interpretation of the various digoxin
7 assays rather than the methodology.

8 It might assist counsel in preparing for
9 those witnesses if we could have some indication in
10 general terms as to the type of evidence they will
11 be called upon to give.

12 MS. CRONK: The next witness after
13 Dr. Cutz is Dr. Ellis. He is being called to give
14 evidence with respect to specific assays that were
15 done on various children in the Hospital, the
16 results that were achieved and his evidence is not
17 going to be directed, as I understand it, outside of
18 his area of expertise to make strict interpretation
19 of those levels, but rather the actual assays that
20 were conducted. And that is principally the Pacsai
21 child, the Estrella child and Miller and Cook, and he
22 as well will be asked to testify concerning assays
23 conducted on tissue samples from various children in
24 the Hospital.

25 Similarly Dr. Soldin will be asked to
testify concerning the actual assays that he



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2 supervised. My current understanding is that involves
3 Allana Miller and Justin Cook, and Dr. Phillips of
4 course will be asked to testify concerning the
5 postmortem digoxin levels that were obtained after
6 March 24th, 1981.

7 MR. TOBIAS: All right, thank you,
8 Miss Cronk.

9 THE COMMISSIONER: Yes, all right,
10 thank you, Doctor.

11 Until tomorrow at 10 o'clock then.
12

13 ---Whereupon the hearing adjourned at 4:20 p.m.
14 until Wednesday, October 12th, 1983 at 10:00 a.m.
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